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ORIGINAL DEPARTMENT.

LECTURE.

OBSTETRICS.¹

BY SAMUEL WOLFE, M. D., OF SKIPPACK, PA.

MR. PRESIDENT AND GENTLEMEN :

In a letter which appeared in the March number of the *American Journal of Obstetrics*, Prof. Saenger describes a number of distinct forms of salpingitis, each with a definite cause, thus differing from those who hold pyo-salpinx to be always due to gonorrhoeal infection. Among other forms he describes a salpingitis septica, corresponding to varieties of puerperal disease, which are ascribed to sepsis. According to his view, not only after labor at full term, but also after abortion or premature labor, a woman is liable to contract this form of the disease, as a concomitant of that form of acute septicemia from which she may happen to suffer. He says: "Salpingitis septica, co-existing with severe puerperal septicemia or 'lymphatic peritonitis,' has never as yet, it is true, given the surgeon an opportunity to remove the principal focus of the disease by extirpation of the tubes. It is possible, however, that under certain circumstances such a procedure might be indicated." After relating two cases in which the tubes had burst from over-distention of pus, and which ended in death, one on the fourth and the other on the twenty-first day after confinement, he adds: "Cases of this kind will be diagnosticated more frequently and more readily as soon as

our attention has been called to them, and we may then expect to hear of their treatment by operation."

This letter appeared, as above stated, in March, 1887. On the 14th of February, Dr. D. Longaker, of Philadelphia, had removed the right tube in a case delivered nine days previously, in the twenty-ninth week of gestation. As this case has not to my knowledge been fully reported, I insert here the following notes obtained from Dr. Longaker :

"The patient was twenty-three years old, and single. She was a robust woman, of large frame, and had always enjoyed good health. She had never had dysmenorrhœa. Early in January, 1887, she had a profuse discharge, like that of acute gonorrhœa. She was well advanced in the sixth month of pregnancy. On February 5th, a twenty-eight weeks' male fetus was born. The woman did fairly well for four days, when she complained of pain and tenderness in left inguinal and hypogastric region. Her tongue was dry; her pulse, 96; her temperature, 102° in the evening. Seven days after delivery she was attacked with intense pain in the left inguinal region. A few hours after the onset of the severe symptoms, her temperature was 96.5°; her pulse, 96; her respiration 24; her knees drawn up. A diagnosis of peritonitis was at once made. Dr. Joseph Price saw the patient a few hours later, and we agreed upon the advisability of laparotomy. Owing to an apparent improvement in her condition, I allowed myself to be persuaded to postpone this for about forty-eight hours. At this time it was evident to all that she would die unless relief came speedily. She readily assented to the operation. On open-

¹An Address delivered before the Medical Society of the State of Pennsylvania, June 30, 1887.

ing the abdominal cavity, general peritonitis was evident. The uterus was fairly involuted. As the intestines were raised from the region of the left cornu uteri, a large amount of stinking pus was discharged—possibly a pint. The left Fallopian tube, the size of a thumb, was removed. The uterus was fixed in the pelvis by peri-uterine inflammation. The right tube was not disturbed. Irrigation with hot water, arrested the hemorrhage. The wound was closed with Chinese silk, and a drainage tube inserted, and the patient reacted promptly and did well for twelve hours, when vomiting set in, and continued until her death, thirty-six hours after the operation."

On the 5th of March, Dr. J. M. Baldy, of Philadelphia, operated on a similar case, (see next week's REPORTER) the patient making a good recovery. This was first case of the kind in which life was saved, and also the first case reported, and therefore entitles Dr. Baldy to priority.

Some difference of opinion exists in regard to the origin of these cases, some holding that the tubal disease is always the result of the gonorrhoeal virus having found its way at some time to the tubes, producing chronic disease there, and under the influence of the puerperal state, being transformed to an acute and violent disorder. Others again believe the puerperal condition may alone be, under the influence of sepsis, chargeable with its origin.

Dr. Baldy believes that it may arise as an acute disorder, in one confinement, may subside into a chronic form (or be even latent), and in a subsequent lying-in again revive and go on to a fatal result, if not promptly recognized and treated by operation.

Thus, in our own State, and within the past year, a great practical advance has been made in the treatment of what is usually called puerperal fever.

A class of cases is provided for which would probably disappoint the most methodical and thorough application of the antiseptic system. If an old salpingitis, due to a former labor, to an old gonorrhoea, or to any other cause, exists, the most rigid observance of antisepsis will hardly exempt from troublesome sequences to parturition. It is true that many believe conception to be impossible, or at most extremely rare, where a tube is diseased; but this view is strongly opposed by others.

However this may be, it seems likely that an era has been inaugurated, in which the indications will be plain, in the small percentage of puerperal diseases which seem not

amenable to the thorough antisepsis of the present day; and to Pennsylvania will belong the honor.

On antiseptic midwifery much has been written, and the details are well worked out. The works of Garrigue² and Richardson³ leave but little to desire, on the part of those who incline to carry out, either in hospitals or private practice, a complete system. Their ground is well supported by logical argument and scientific facts, and with the aid of Dr. Hirst's monograph on "The Death-rate of Lying-in Hospitals in the United States,"⁴ these works make a strong presentation of the subject.

It is, indeed, at present, more a question of antisepsis than of asepsis. The existence of sepsis is hardly denied by any authority, although Saenger accuses Tait of standing in this position. He says:⁵ "He (Tait) does not believe in sepsis at all, does not believe in infection, denies the principles on which modern surgery and obstetrics is based. He has been taught nothing by the researches of Semmelweis and Lister, Pasteur and Koch." This being written in the warmth of a reply to an attack by Tait on Saenger, may not be a fair statement of Tait's views, for, as Marcy says: "The most scrupulous Listerian disciple cannot outvie Mr. Tait in enforced cleanliness. His sponges are an especial care and just pride, while no operator more carefully removes the very material, too often left in the pelvic basin, which will serve as food for bacterial development."⁶

Sepsis being admitted, asepsis must be secured, and the problem lies in the method. Whether by a system which aims at a certain destruction of all manner of germs, by chemicals known to be capable of exercising such an effect, or by physical or hygienic methods which will insure their exclusion, is probably more a question of taste than of belief.

When the choice of germicides is to be made, so far as experiment has demonstrated their virtues and practice acquainted us with results, we would hardly find it necessary to consider more than two drugs, the bi-chloride and the bin-iodide of mercury. The former has an extensive history as a germicide, while the latter has been brought to the notice of the profession by Dr. E. P.

² *Antiseptic Midwifery.*

³ *Boston Med. and Surg. Journal*, Jan. 27th, 1887.

⁴ *The Medical News*, March 5th, 1887.

⁵ *Amer. Obstet. Journal*, March, 1887.

⁶ *Med. Register*, Feb. 12th, 1887.

Bernardy,⁷ of Philadelphia.

The claims for it, over sublimate, are, greater germicide properties in weaker solutions, and lesser irritation and danger of poisoning. Recent experiments by Dr. P. K. Bolshepolsky,⁸ of St. Petersburg, fully confirm the observations of Dr. Bernardy.

Other substances have been brought forward, each having some advantage or some special application urged for it, amongst which are boracic acid, alcohol⁹ by Dr. Paramore, of London; carbolic acid, thymol and iodoform¹⁰ by C. Braun, of Vienna.

As to the extent to which antiseptic precautions shall be practiced, there are those who think it unjustifiable, and some even criminally negligent, to treat any case, at any period, either during labor or the lying-in period, without the adoption of a full line of these tactics. Others again, and among these are many whose opinions are entitled to great respect, believe that the practice in hospitals and private may largely differ, the precautions necessary in the former being to a large extent not only unnecessary and superfluous, but even liable to work injury in the latter. Distinctions between city and country practice are also made.

There are many shades of opinion as to what constitutes a complete system of antiseptics. Bearing on these points, I will read a few references which, though drawn partly from the field of abdominal or general surgery, and in other instances relating only to intra-uterine injections, or some special part of the antiseptic plan, yet have their application here.

Dr. Graily Hewitt says:¹¹ "The practice of midwifery in private and in a lying-in hospital cannot be looked upon as identical, so far as the frequent use of antiseptic injections is concerned. . . . If it went about that the internal injection of a dangerous antiseptic, such as corrosive sublimate, was essential to the safety of the lying-in patient, it would be the cause of infinite mischief. No doubt in a lying-in hospital extreme precaution is justifiable, but in private practice less dangerous materials can be employed, and frequent use of injections cannot be held to be necessary."

Dr. Champneys says:¹² "Private practice and hospital practice differ in one respect;

in both the patient requires protection from the accoucheur and nurse; but the latter also requires protection from other patients. We must balance the risk of sepsis against the risk of mercurialism, and I unhesitatingly embrace the latter."

Dr. John Phillips says:¹³—"The question of intra-uterine injections is sub-judice. As regards vaginal injections of sublimate, they might be safe, if there are no lacerations, not otherwise."

Dr. Sutton says:—"If Listerism has taught us anything, it is cleanliness in surgery." "It is clearly proven that a specific dressing to every wound is unnecessary, and also that specific dressings fail in the object intended." "He (the surgeon) must always keep before him, the fact that no system of antiseptics, will cover dirty and slovenly surgery."

Dr. Hiram Corson says:¹⁴—"It (puerperal fever) is a disease exceedingly rare in the country. If it is caused by the germs which are so guarded against in cities, and especially in hospitals, they are inactive, if they exist at all, in the country; and therefore, the directions so urged by Dr. Elliott and Carl Braun, and others, are not needed with us."

Dr. Joseph Price says:¹⁵—"Distance dirt and all will be well."

Dr. Hirst,¹⁷ in the Maternity Hospital, in Philadelphia, and in his private practice, carries out a plan by which 210 women have been delivered, without a death, which consists of the usual disinfection of hands, &c., with sublimate solution, a blanket previously soaked in a 1 to 2000 solution, and dried, on which the woman lies, and a regular system of ablutions of the external genitals with a 1 to 2000 solution. In the hospital a routine 1 to 4000 injection is given from a fountain syringe, immediately after the close of the third stage of labor.

Dr. Longaker,¹⁸ while believing in great precautions, thinks injections should be restricted to cases in which some obstetric operation, such as version, forceps, craniotomy, had been performed, and then the iodoform pencil should follow the injection, which should have been intra-uterine. He says injections "are unnecessary in normal cases, and may do harm." He regards the occlusion dressing of Garrigues as indispensable

⁷ *Med. Times (Phila.)*, June 4th, 1885, and April 17th, 1886.

⁸ *Vratch No. 11*, 1887, p. 220.

⁹ *Amer. Journal of Obstet.*, Feb., 1887, p. 223.

¹⁰ *Amer. Journal of Obstet.*, Feb., 1887, p. 212.

¹¹ *Amer. Obstet. Journal*, Feb., 1887, p. 212.

¹² *Amer. Obstet. Journal*, Feb., 1887, p. 212.

¹³ *Amer. Obstet. Jour.*, Feb. 1887, p. 211.

¹⁴ *Gynecological Transactions*, Vol. viii.

¹⁵ *N. Y. Med. Jour.*, May 15th, 22d, and 29th, 1886.

¹⁶ Letter to the Author.

¹⁷ Letter to the Author.

¹⁸ Letter to the Author.

in hospital, but in private practice finds he "gets along as well without it."

The annual reports of the Philadelphia Dispensary, for the years 1883, 1884, 1885, and 1886, show a total of 810 confinement cases attended from that institution, all at their homes. These homes, it is not necessary to state, were, for the most part, in the most unsanitary condition in every respect. If I have been rightly informed, and I have taken pains to be, no antiseptic precautions were taken in any of these cases, and yet there was not a single death amongst them. From private sources, I learn, that the cases which have occurred during the present year, up to May, at least, have also been without mortality. The grand total, therefore, comes near reaching that of Tarnier (1000 cases), and the result—"without a death"—is more remarkable, since the attendants were largely young men, with but little experience.

I have no desire to underrate the intelligence and progressive spirit of country practitioners. I would rather believe them to be, after the exclusion of the great teachers and leaders of medical thought, the peers of their town *confrères*. But from what I know of them and of country practice, I am doubtful whether the earnest plea of Garrigues to them, to adopt the antiseptic system, or any other argument that can be made, will prevail with the great majority of the present incumbents. It may be as Marcy says, that the men who are now receiving their education, and who are having the principles of the antiseptic method thoroughly ingrained upon them, will successfully introduce it. There are many reasons, pertaining both to the practitioner and his patrons, which make it unlikely that there will be the radical change which would occur under the new system. Though they may not be regarded as sufficient by those who advocate the latter; they will have accomplished their purpose, when they are sufficient to those contented to practice under the old order. They are in fact more weighty than those who have never practiced in the country can comprehend, and I am of the opinion that many hundreds of positions might be found in Pennsylvania alone, which if filled for one year by ardent exponents of the antiseptic system, would convince them, that their predecessors were entitled to some little justification in letting the traditional one in one hundred die of sepsis.

They but seldom are engaged in advance to attend patients in confinement, and have therefore no opportunity to arrange the preliminaries. They are often called just in

time to support the head as it is passing the external outlet, and making solutions, and soaking the hands for five minutes at this juncture, before touching the patient, would not be likely to be thought very fitting. And yet it is risky to the reputation of a country practitioner not to go through the same routine in every case, as his patients are constantly associating with each other and comparing notes. Then again if the idea was fostered that there was danger at every point in a midwifery case, the hopeful spirit which we all so much value would be violently disturbed, and nowhere so much so, as in the simple-minded, self-engrossed, country woman. The nursing, too, is hardly as intelligent as that which is commanded in cities; and far less so than that in hospitals. The accoucheur seldom sees his patient more than twice after the day of labor, and must content himself with a very small fee for even so small a service. Moreover he has been going on for years, probably, without a fatal or even a seriously ill case, and is not likely to be terrified into a radical change of his methods by collective statistics, which are drawn from very remote sources. "Letting good enough alone" is apt to be a stubborn principle with him.

The admitted dangers of poisoning are likely to have considerable weight, and that these dangers would be greater in the hands of the busy practitioners and ignorant nurses, under whose care after all the great majority of puerperal women find themselves, than they have been under the management of the skillful class of practitioners to which the antiseptic practice has been thus far mainly confined, is hardly to be contraverted.

Dr. Lucien Butte reports, in a recent number of a French journal, some twenty cases in which the employment of sublimate had caused death. Doleris and Butte, in December, 1886,¹⁰ publish their conclusions from a series of experimental researches, under four heads, the fourth reading thus: "In the face of its possibly dangerous results, it is questionable if sublimate should be used in obstetrics and gynæcology."

If then for some time to come, antiseptic midwifery mainly remains confined to hospitals, and to the private practice of those connected with them, and to those whose consciences will not rest unless they are steeped in sublimate solution, we should not cry homicide and malpractice on the poor man who dares to make a vaginal examina-

¹⁰ *Nouv. Arch. de Gynæc.*

tion without the "strictest antiseptic precautions."

In the treatment of mastitis, the old system of breast-pumping has given way to equable pressure by a bandage, supplemented in severe cases by the application of the ice-bag. The treatment of inflammatory diseases of any organ by cold has long had an able advocate and exponent in Dr. Hiram Corson, of Conshohocken, and to bring forth anything that is new to him in this line would probably severely puzzle the scientific world.

Antiseptic midwifery applied to the breasts in the manner taught by Garrigues, it is claimed, will prevent the occurrence of mastitis, and antiseptic surgery adopted in the treatment of mammary abscess, will very speedily cure.

Dr. Longaker, in an article on this subject³⁰ reaches the following conclusions:

- (1) Milk retention is not a cause of mastitis.
- (2) Milk retained in an inflamed breast does no harm.
- (3) Any effort to remove the secretion increases the intensity of the inflammation by stimulating the functional activity of the gland.
- (4) The fundamental principle to be observed in the treatment of mastitis is rest. This will prevent suppuration.
- (5) In suppuration, early incision, under antiseptic precautions and drainage, is to be strongly urged.

A correspondent of the *British Medical Journal* advocates for inflammation of the breast "effervescing citrate of potash, with about fifteen minims of sweet spirits of nitre and the same quantity of sal volatile every four hours." To ease pain and help resolution, he advises hot fomentations containing belladonna.

Mr. Miall³¹ says: "When mammary abscess is on the point of forming, I have frequently seen all the symptoms rapidly disappear in a few hours under the influence of fomentations with hot water and carbonate of ammonia, an ounce of the carbonate to a pint of water." The nipples must be protected.

I have seen good results from the liberal use of an ointment of calomel (3j—3j), conjoined to appropriate internal treatment and care of the nipples, with an efficient sling for the inflamed organ.

Touching the value of support to the perineum, Dr. Bahnson, of Salem, N. C., gives

in a recent article³² his opinion of the cause of lacerations, and his method of preventing them, which he regards as superior to other procedures. He does not believe that the head causes the laceration, but ascribes it to the cutting of the acromion which ploughs over the perineal floor. The opinions expressed by Dr. Baldy³³ also make it doubtful whether we are doing all for the woman, that we are apt to fancy we are, in supporting the perineum. He says "if we hold the head back, the vis à tergo must be spent somewhere, and that somewhere is the pelvic floor." He points out that the skin is frequently intact, while the structures internal to the skin, forming the posterior vaginal wall, are torn and prolapsed, a condition for which operative procedures become necessary.

The idea of the hand on the perineum at the moment of the passage of the head over it, is, in my mind, not to prevent the head from moving forward, but to secure its direction in conformity with the natural curve of the distended, but not torn, perineum. The unsupported parts may not furnish sufficient resistance, and may, under a sudden force, give way, an accident probably less likely to occur when a tactus eruditus is in requisition.

Lanolin has been brought forward³⁴ as far preferable to lard or any other unguent, for overcoming rigidity of the perineum.

While we are aiming at the prevention of lacerations, the Burmese midwife, according to Dr. T. F. Pedley, of Rangoon,³⁵ in primipara, tears the perineum with her thumbnail, which she has cultivated into a long and sharp instrument for this very purpose; or if not furnished with this terrible tool from her hand, she is sure to have it on her great toe from which position she wields it with equally effective fiendishness.

And finally, in regard to this caption, I have somewhere seen a case reported, in which the accoucheur's attention was called to something being expelled from the rectum, as the head was descending, and finding it to be a sausage several feet in length, which had been placed there to insure expulsion of the product of conception by way of the natural outlet.

In the March and April numbers of the *American Journal of Obstetrics*, for this year, Dr. King, of Washington, brings forward a new and very interesting theory on the cause

³⁰ MED. AND SURG. REP., Jan. 29, 1887.

³¹ *British Medical Journal*.

³² *Virginia Med. Monthly*, April, 1887.

³³ *Amer. Obstet. Jour.*, April, 1887.

³⁴ *Quar. Therap. Review*, January, 1887.

³⁵ *Amer. Obstet. Jour.*, April, 1887.

of the renal troubles of pregnancy. He maintains the normal position in utero to be oblique, with the pelvic extremity towards the one side, usually the right, and the cephalic towards the other, resting in the iliac fossa, above the pelvic brim. So long as this position is preserved the large abdominal vessels escape pressure; when it is changed to the vertical, which may occur from numerous causes, compression occurs, and renal troubles, with all their serious consequences appear.

The electric shock, for the destruction of the life of the foetus, in extra uterine gestation, in the early months, has become the recognized treatment for that condition, although laparotomy too has its advocates, amongst whom is Gallabin, whose work on obstetrics has appeared within the year.

Among the other new works, are those of Parvin, King, Mundé and Charpentier.

While I recognize the imperfection of this sketch, and feel that what has been done within the year, to which no reference is made, may far exceed in importance that which has been noticed, without, however, any intentional slight, I may yet hope that I have brought this subject before you in such a way that you may see that the march of progress has been rapid; that the great art of midwifery has gained in useful acquisitions; that the diseases of the mothers of our time are being sedulously studied; and that what was an obscure art, still allowed to smoulder under ignorance and superstition, when the other departments of medicine had long since emerged from the darkness of former ages, is now amongst the most finished of the specialties, and the one which probably leads in the application of the most advanced principles of practice.

—"The Uses of Adhesive Plaster in Orthopædic Surgery" is discussed in a very clear and practical way by A. B. Judson, M. D., of New York. The pamphlet before us is reprinted from *The New York Medical Journal* of June 4, 1887.

—Dr. Henry Boynton, of Woodstock, Vt., in a recent address on alcohol and opium, said that the use of opium was increasing in that locality. The four druggists report sales of opium in a year sufficient to make one hundred gallons of laudanum. This is the equivalent of one hundred and sixty-seven ounces of morphine. Of this whole amount only *five per cent.* is sold to physicians.

COMMUNICATIONS.

THE USE OF THE EXPECTORANTS IN THE PULMONARY DISEASES.

BY J. CHRIS LANGE, M. D.
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It is the object of this paper to present some considerations upon the customary employment of the expectorants in the treatment of pulmonary diseases. The term, expectorant, is applied in the *Materia Medica* to a class of remedies the effects of which are said to embrace a modification of the condition of inflamed mucous surfaces, as a result of which their secretion is increased in quantity and decreased in viscosity; in other words cough is "loosened" and expectoration is facilitated. Senega and scilla, classed in the *Materia Medica* as blennorrhethics, and ipecacuanha and sanguinaria, of the class of emetics, are the substances some preparation of one or more of which most frequently constitutes the potent ingredient of the conventional cough mixture. Such a mixture is commonly exhibited in diseases accompanied by cough; that is to say, in pulmonary diseases. In this class of affections a cough mixture is a clinical necessity. Patients demand a medicine addressed directly to the most prominent symptom of these affections, namely, to the cough. Very frequently the only indication for treatment which exists in such cases is the exhibition of some remedy to allay the cough. As a consequence of this demand and of this indication, it is almost universal practice to administer in such diseases some compound or mixture containing a preparation of ipecacuanha, scilla, senega, sanguinaria, or some other of the expectorants.

It is proper to ask, therefore, upon what grounds this common practice rests? Are these grounds good and sufficient? Is this practice based upon the results of clinical experience, or is it supported alone by the arbitrary and fallacious classifications of the *Materia Medica*?

The natural history of the most common of the pulmonary diseases, acute, simple bronchitis, embraces a duration of from ten to twelve days. It may be divided into two stages; during the first stage, a period of from three to five days, the sputum is transparent, scanty and viscid; during the last stage the sputum becomes abundant, opaque and muco-purulent. This is the expectoration of acute simple bronchitis

when the disease pursues its course untreated. I have many times verified it and have records of many cases. If now the described desirable effects of the expectorants follow their administration, they should be appreciable in the comparatively simple inflammation mentioned. That is to say, in other words, the first stage of an acute simple bronchitis should be shortened, or, if you please, the duration of the affection should be shortened. If this putative effect of the expectorants obtains, the stage of scanty and viscid sputum should not endure so long, and the stage of free expectoration should appear earlier than is the rule in cases untreated. Does this result follow in cases treated by the expectorants? I have records, also, of many cases of acute simple bronchitis treated by the expectorants; a comparison of my record of cases so treated with that of cases entirely untreated demonstrates the result of the administration of the expectorants in this inflammation to be *nil*. This comparison shows no diminution in the duration of the first stage, and no diminution in the duration of the affection. In my experience, therefore, the reputed action of the expectorants in acute simple bronchitis is merely a superstition. The disease runs its course precisely as though untreated. In consequence, my employment of these remedies would rest, not upon good and sufficient grounds, not upon the results of clinical experience, but upon a fallacious classification of the *Materia Medica*, and upon custom which makes laws by no means invariably wise. And the same is true of my observations regarding laryngitis, pleuritis, and pneumonitis; these affections run their course uninfluenced by the administration of the expectorants. If these affections run their natural course, if their cough is uninterrupted, uninfluenced by the administration of these remedies, then despite a therapeutic legend, the usefulness of the expectorants in these inflammations is not warranted by clinical experience.

The study of the effect of the expectorants in chronic diseases of the pulmonary structures abounds in difficulties which are absent from that of the acute diseases. It may be aphoristically said that the intensity, duration and frequency of cough is in proportion to the difficulty of expectoration; and that this latter is in proportion to the scantiness and viscosity of the sputum. The cough mixtures, of which the potent ingredients are the expectorants, are addressed directly to the cough; they are administered for their putative action, the modi-

fication of the inflamed mucous membrane, resulting in a sputum increased in quantity and decreased in viscosity. That is to say in other words, they are administered to "loosen the cough." The question to be answered is, does clinical experience demonstrate that this effect follows the administration of the expectorants in the chronic pulmonary diseases?

The difficulties to answer this question are many. They are the ever-varying conditions of the sputum, as to quantity and viscosity, which belong to the natural, as well as to the clinical history of these affections. The intrinsic causes productive of these varying conditions, are the changes involved in the progress and retrogression of these diseases, and in their complications. The extrinsic causes active to the same end are innumerable; prominent among them are atmospheric changes as regards temperature, humidity, and direction of the wind, and changes in the life and habits of the patient. Other difficulties emanate from the desponding or hopeful or petulant patient; the subjective descriptions of cough and sputum, the subjective certainty of improvement or decline, of restoration or destruction. Superadded to these difficulties are those generated by the unscientific conclusions of the physician, whose laudable desire to be useful, whose veneration for time-honored and unquestioned propriety, are prone to picture to him good results where none exist, and to make natural changes appear as consequences of his therapeutics. These difficulties beset the way of the clinical investigation of the effects of the expectorants in chronic pulmonary diseases. They constitute effective bars to entrance into, and exploration of, this field,—bars unsurmounted and yet unsurmountable. Therefore, to the question: Does clinical experience demonstrate that the putative good effects of the expectorants follow their administration in chronic pulmonary diseases? we have to answer: This is still undetermined. And from this it follows that the customary exhibition of the expectorants in these affections rests, not upon results of clinical experience, but upon an honored classification of the *materia medica*.

Let us consider other effects of the expectorants. They increase the action of the skin and that of all secretory and excretory glands. In other words they effect a derivative revulsion; they produce a plethora of the abdominal viscera, the glands and skin, and a corresponding anæmia of the thoracic

viscera. Is this action of the expectorants desirable in the pulmonary diseases? There is no clinical evidence to prove this action a beneficial one in the acute pulmonary affections; there are grounds to justify the belief that, in chronic pulmonary affections, this action is an unfavorable one. The chronic pulmonary diseases embrace in their morbid anatomy blood stasis, œdema, infarction, hypertrophy, atrophy, degeneration, abscess, necrobiosis, etc., processes and conditions which have to do, not with an increased blood supply, but with a blood supply which is diminished. The presence of the greater than normal quantity of blood in the pulmonary structures is not an active congestion, like that of the first stage of a croupous pneumonia, but a passive one like that of a protruding hemorrhoid. Such processes and conditions thrive upon a diminution of the arterial blood supply, for the reason that this involves the presence of an increased quantity of venous blood. In short, as stasis is increased by a diminished arterial supply, and as stasis is a factor, as well as a cause and an effect, of the destructive processes and conditions constituting chronic pulmonary diseases, its diminution instead of its increase should be the object sought to be attained by treatment. From this consideration a rational conclusion, repeatedly proven correct by clinical experience, is established. It is that, in chronic pulmonary diseases, derivative revulsion is an injudicious measure of treatment; that it is a depressing measure; and that its results, like those of all antiphlogistic treatment, are bad.

If this effect, the diversion of blood to other parts, is desirable or is desired in any case of pulmonary disease, other remedies than the expectorants will produce it much more energetically; but it is not for this effect the expectorants are employed; this effect is secondary, minor, incidental only, and quite unimportant. This effect has not established and does not maintain the customary exhibition of the expectorants. This is accomplished solely by their putative action, to increase the quantity and to decrease the viscosity of the sputum,—to “loosen the cough.”

Finally, we have to consider one other action of the expectorants. This, also, is an action, which has not established and does not maintain their customary exhibition; this action, also, is secondary, minor, incidental only, and receives no attention.

This effect is nausea. Nausea is a powerful antiphlogistic. A nauseated patient is

subjected to a potential modification of his nervous system, which breeds disturbances throughout the whole economy. This is manifested by a thready pulse, a cool surface bathed in clammy sweat and cold extremities, by pallor with bloodless prolabia, and a relaxation of the whole muscular system, including often the sphincters. In the nauseated patient life appears to be at its end. Nausea is one of the most energetic immediate sedatives, to which free bleeding alone can be compared. This is nausea to the point of emesis. It is not this point, however, which is reached in the administration of the expectorants, excepting those instances in which it is desired to vomit the patient; the exhibition of these remedies does not reach this point of nausea. Pronounced nausea is not produced by the proper dose of an expectorant, or if it be, the dose is diminished. Nevertheless, a degree of nausea is a result of the employment of these remedies, and this is more or less manifest according to the size of the dose and the susceptibility of the patient. The administration of expectorants results in a degree of nausea, the existence of which is readily appreciable in the physiological state; in the pathological state its existence is most obviously made manifest by the destruction of an already impaired appetite, by the substitution, for a limited power of taking nutriment, of loathing for all food. This I have frequently verified by the alternate administration and withdrawal of these agents in the same patient. Further, by the exhibition of the expectorants to healthy persons, some malaise, a pasty mouth, a furred tongue, complete anorexia, and epigastric tenderness, are produced in the course of a very few days. These symptoms belong to the physiological effects of the expectorants; these symptoms also constitute the semiology of a mild sub-acute gastritis. The obvious inference is that the latter affection is a consequence of the exhibition of the expectorants.

Let us apply these considerations to the management of pulmonary diseases. Are these depressing and spoliative effects desirable, let us ask, in phthisis? An answer is obviously unnecessary. Yet what is more common than to administer some cough mixture containing an expectorant, during the course of this affection? It is expedient, a matter of course, routine. An indication exists for, and the patient demands, some remedy addressed directly to the cough; the time-honored expectorant is chosen; its putative expectorant effect is of such import-

ance that its perturbing and spoliative effects are forgotten or ignored.

Equally injudicious is this treatment when employed in chronic bronchitis. An affection which frequently entails upon the patient a dilated heart, and the pathological changes of which depend largely upon blood stasis, contra-indicates the exhibition of every agent which numbers among its affects a sedation of the heart and a diminution of nutritive supplies. The consequences of such a remedy, though they may be long endured, and though they may be difficult to measure, are certain to follow its administration: they are debilities which in and of themselves may be effectual bars to a recovery. Yet more pernicious is this treatment when employed in the pneumonia of old age, which disease is frequently a process of chronicity. As a disease imperatively requiring, above all else, most energetic supporting treatment, one in which all depressing measures are clearly contraindicated, its proper management debars the use of the expectorants; and if these remedies enter into its treatment this therapeusis deserves the title which its result confers upon it.

The exhibition of the expectorants in the acute pulmonary diseases which are without danger to life can be objected to only on the grounds that their expectorant action is observed to not follow their administration, that their revulsive action is too feeble to be of service, and that as nauseants the worst they accomplish is to increase somewhat the patients' discomfort and debility. If our therapeutic resources do not embrace a better treatment for the cough of an acute simple bronchitis, for instance, then no more potent objections than those cited may be made to the administration of expectorants, perhaps; and yet it is conceivable how, particularly in the young, the old and the feeble, this treatment may be a causative factor in the extension of a bronchial inflammation which terminates in catarrhal pneumonia. It is conceivable how the depressing effects of expectorants may constitute the essential, because the necessary, factor which induces an extension and prevents a resolution of inflammation; how these effects may constitute the metaphorical feather which breaks the camel's back. If this be true it is a grave objection to this treatment which must be added to the trivial ones.

In another class of acute pulmonary diseases, namely, those in which danger to life is by apnoea only, the trivial objections to the employment of expectorants can alone be urged, provided this treatment is not

allowed to displace proper and more energetic measures. In such affections we are not concerned with asthenia; we know the patient to be safe as far as exhaustion is concerned; hence no grave objection to the use of the expectorants exists, and the trivial ones are only to be remembered. These objections become potent however in all acute pulmonary diseases in which the danger is from asthenia. That is to say in other words, in all such diseases in which, if they end fatally, death is caused by the exhaustion of the patient. A class of diseases of which Dr. Flint has said, "The ending is a question to be decided by the tolerance of the patient; if his tolerance hold out, the ending is in recovery; if it do not, the ending is in death." This class embraces the majority of cases of acute pulmonary diseases, and their proper treatment presents this pre-eminent indication, to strengthen and to lengthen the tolerance of the patient. If the tolerance of the patient hold out the ending is in recovery; if it do not the ending is in death. The tolerance of a patient is not strengthened and lengthened by the exhibition of the expectorants, but is, on the other hand, weakened and shortened by it; and, again, it is conceivable how this weakening and shortening, be it ever so limited and difficult to measure, may constitute that factor in a case which determines a fatal ending.

TRUE AND SIMULATED INSANITY IN THE CRIME CLASS.

BY DR. WM. DUFFIELD ROBINSON,
Physician in Chief of the Eastern State Penitentiary.

Abstract of a paper read before the Philadelphia
Neurological Society.

In the general population there is a distinct class known as the "*Crime Class*," and most State Prison offences are committed by this class. They seldom reform, but end in death, lives passed in crime and infamy. They have as little control of their natural inclination to wrong doing as a drunkard has over his desire for liquor. They are seldom given to rum-drinking and rarely permit themselves to become intoxicated. They have little sense of honor among themselves, and see little, if any, moral wrong in their crimes, regarding the man who brings them to justice as worse than themselves. They do not believe in sexual purity, and are given to excessive venery. They squander their money when they have it, have little fear of death, and in many cases are infidels. They form strong

but capricious and unstable attachments. The class includes persons of all grades of intelligence and education. With them crime is a monomaniacal infatuation. They are distinguished by abnormal shrewdness and cunning, either inherited or developed by life-long practice in evading detection. Each devotes himself for life to his own special line of criminal work.

As a class they are deficient physically and mentally; 20 per cent. have had syphilis before they are 40 years old; neurotic diseases are common among them; they are frequently the subjects of epilepsy, and mental diseases prevail among them in a far larger proportion than among the general inhabitants. Fully 10 per cent. develop some form of mental disease before death. Three or more deaths from tubercular diseases occur in a family in 76¼ per cent. of such convicts.

The criminal tendency of individuals of this class is almost always inherited, and they have scarcely any control of it.

About 6 per cent. of convicts show a strong inherited tendency to insanity, and over 17 per cent. of the convicts in the Eastern Penitentiary of Pennsylvania show family crime histories. Where two or more members of a family are convicts, they almost invariably show the distinctive characteristics of the crime class.

During the five years I have been physician to the Eastern Penitentiary, I have had to deal with 3500 convicts. Of these 245 were insane upon admission, 40 developed insanity during their incarceration, and 20 simulated insanity. Among the rest were to be found many who were feeble minded, epileptic, idiotic, or with imperfectly developed intelligence.

Many different forms of insanity prevail among convicts, the most usual being (1) delusions of attempts to introduce poison in their food; (2) delusions of bodily torture by electricity—this class rarely recover, and autopsies reveal decided cerebral lesions; (3) delusions of persecution and threatened bodily violence; (4) religious exaltation; (5) homicidal mania.

Many insane criminals have been criminals before they became insane; they are not criminals because of insanity, but independently of it, and they would be equally criminal if not insane.

Simulation of insanity is rarely met with by the general practitioner, since it is confined almost exclusively to prisons, the army, and the navy, where alone a motive for it exists.

It would be hard (if possible), to make the

general practitioner or specialist in nervous diseases believe how deceptively an ignorant, illiterate criminal can play the part of a lunatic. I have seen twenty cases in which the simulation would puzzle or deceive any physician. The efforts have lasted for days or months, and in many cases I could not have believed that the insanity was not real, had not the patient eventually confessed his simulation and abandoned it.

These subjects never claim to be insane. They usually first threaten suicide or make a safe pretense at attempting it. If this fails in securing for them what they desire, they soon claim as facts what is necessarily false. These false beliefs and delusions they persist in, often adding others of correlated character.

While some do such simulation badly, each does what he thinks will be most likely to make you believe him demented. A prolonged study of any one of them, will in time create a doubt as to its genuineness, to the unprejudiced observer. Insanity is sometimes produced by *continued* effort at simulating, which overtaxes the brain.

From my observations I would ask your attention to the following few cases:

Case 1—A convict began his masquerade about a month after reception by a claim of delusions and by violent outbreaks of violence and passion. After a few months he had reduced himself to a most disgusting and deplorable condition by his acts and filthy habits, in spite of constant efforts to keep him cleanly. He seemed to have arrived at the last stages of dementia, and a commission of our most prominent expert specialists in mental diseases, appointed by the court, declared him to be unquestionably insane. A month later, after an encounter with his keeper, in which he was for the first time punished, he asked to be put in another cell to work, and said his insanity was all a simulation, in the hope of removal to an asylum. From that hour he never showed the slightest indication of mental disease during the next six years.

Case 2—The Emma Bickel case need only be mentioned to demonstrate how easily a claim of insanity may be supported by medical testimony, although the subject is perfectly sane. Several murderers have recently been declared insane by experts; but when that failed in its purpose, and execution became inevitable, the last days of several of them were noted for entire absence of insanity or delusion, and full appreciation of their deeds, responsibility and impending punishment.

Case 3—An Englishman received as a convict a few months ago, soon after reception showed signs of delusional insanity, followed eventually by apparent apoplexy, very correctly simulated. Etherization, with a show of intended application of actual cautery, entirely and permanently cured the apoplexy and insanity as soon as the stage of ether intoxication had been reached.

Case 4—An intelligent farmer, guilty of murder, whose mental soundness was questioned, was not hung, but the grade of his crime was reduced to murder in the second degree. He was recently received to serve an eight-years' sentence in the penitentiary. On reception he was apparently in the last stages of dementia. Being convinced that it was not genuine, I assured him he would not be removed to an asylum, and advised him to give up his play, and behave like a man. A little rough usage by speech and a couple of shakings, in a few days convinced him that his attempt had failed, and he suddenly gave up the play, and has since been a perfectly sane, intelligent man.

Case 5—Dr. J. Wm. White, in one of the annual reports of the penitentiary, describes a case of a man who went on to the most loathsome and filthy practices of the badly demented, but who afterward acknowledged it all a masquerade, and ceased the pretence.

Case 6—The convict Taylor was not thought to be insane by any member of our profession, or the laity, whose study of him had been careful and continued over some months. His last days indicated his sanity, and he pleaded for pardon for the charges which he had made, and which he said he knew were false. The autopsy in his case revealed no brain lesion, but a brain characteristic of the low crime class.

Medical testimony has lost much of its proper influence over jurymen, probably caused by the bitter partisan position which experts permit themselves to take, imposing their varying opinions as positive facts on every one where opportunity offers.

Should the court conduct the mental investigation of prisoners, instead of either the prosecution or defense, it would do much toward elevating medical testimony to its proper place, and prevent its so degenerating in the estimation of the laity, as often to be successfully ridiculed.

—An Appendix to Neale's "Medical Digest," including the years 1882-3-4-5 and the early part of 1886, has just been published, and brings this valuable work as nearly as possible down to date.

BRONCHITIS FROM MECHANICAL IRRITATION.

BY T. C. SMITH, M. D., OF AURORA, IND.

The following case is of interest, as showing how easily we may sometimes be placed in error in diagnosis and treatment, and indicates how very serious consequences may result without our even suspecting the true exciting cause.

Bertha C., aged 5 years, is usually healthy and robust, though sometimes troubled with obstinate spasmodic cough resulting from cold and former tonsillitis. This, however, could be allayed by the active use of expectorants—chiefly bromides—or syrup ammon. iodid. She was brought to me the last week in February, 1887, with a very severe spasmodic cough that caused her mother to think she had an attack of pertussis. This I did not believe. Physical examination caused me to pronounce it a case of sub-acute bronchitis. There was slight febrile excitement, considerable "nervousness," pulse 110, cheeks flushed, increased respirations accompanied with considerable lifting of the shoulders at every inspiration, and a disposition to cough on expiration; there was no marked cyanosis. The respiratory sounds were loud, well marked and dry. The sibilant and sonorous râles were loud and distinct with both inspiration and expiration. The expectoration was white, tough, not very adhesive. A few times it was tinged with blood. The dyspnoea was considerable on exercise and at night on going to bed. The cough mixtures failed to give satisfactory relief, though they were persistently used, and as strongly anodyne, anti-spasmodic and expectorant as was safe to give. I should have mentioned before that resonance was fairly normal all over both lungs, being perhaps a little clearer on the right than left side.

A month of treatment availed nothing for real improvement. The faithful parents were becoming discouraged, and were apprehensive of chronic lung disease. Finally the child had an unusually severe spasm of coughing and threw out of her mouth a little brown triangular object, quite a half inch on each of its three sides, and very sharp at one point. Inspection proved it to be a piece of hazelnut shell that the child had drawn down the trachea a month before. Her mother distinctly remembered the time when the child seemed to choke a little and cough severely while eating these nuts, but as she soon ceased to be troubled for that

time, it did not occur to her that any part of the shell had gone into the bronchia. After its expulsion the cough ceased at once.

This case reminds me of one that was reported by—I believe—Dr. A. T. Keyt, to the Ohio State Med. Society, about 1872, where the case was diagnosed as tubercular phthisis, and was soon expected to die, when, all unexpectedly, a splinter of hard wood was expectorated and a fairly rapid recovery followed. I give this from memory, and believe I have stated it correctly, as then reported.

ACUTE MANIA CURED BY HEROIC TREATMENT.

BY H. V. SWERINGEN, A. M., M. D., FORT WAYNE, IND.

A young Irish woman. Married twelve or thirteen years. Has six children living. Had several abortions. Naturally anæmic. Ambitious and industrious. Has done all her own work except during periods of confinement.

I have given her, with decided benefit, the usual remedies prescribed for anæmia, chlorosis, leucocythemia, neurasthenia, etc., etc. But as soon as she felt better they were discontinued until a relapse would occur, when, after bearing it as long as she could, she would again apply for medical aid, and so on *ad infinitum*.

About nine or ten weeks after the birth of her last babe which now (June 21) is about three months old, she had one night a very peculiar mental attack, which aroused her household and neighbors.

She labored under the delusion that her husband, a locomotive engineer then out on his run, was killed. In spite of the assurances of her friends to the contrary, she would not be comforted, but screamed, lamented and cried at a furious rate, until a short time before my visit on the following morning, when she seemed to recover her usual composure, but it was quite plain that something was radically wrong with her mind.

While she answered my questions rationally enough, she was in what is called a "nervous" state, with an anxious, unnatural expression of face.

In answer to the usual questions from friends, I told them that her condition was due, in my opinion, to the fact that she did not have blood enough in her body to nourish her brain, and that as a result, it had lost its equilibrium, the cerebral cells having be-

come irritated, disconnected, their continuity interrupted, etc., etc., or words to that effect.

The idea of puerperal mania, or insanity, suggested itself; but I could find nothing in the case to support it other than the facts above given.

I requested the friends, however, to watch her very closely day and night, telling them she would be apt to kill her babe, throw herself in the cistern or river, or enact some other fearful tragedy.

She passed the day fairly well, but in the night again became delirious or maniacal, requiring restraint, the attendants being obliged to hold her in bed, from which she would occasionally start or rise up suddenly seeing something horrible to look at: a fire burning up a family, or a child drowning, or sights of this nature.

I considered the bromides contraindicated in the case, for reasons which are at once apparent to the reader, and endeavored to control her excessive, obstinate wakefulness by food, stimulants and tonics. But she became wholly indifferent to the entreaties of her friends, and refused to eat or drink any and all preparations offered to her.

I gave her various hypnotics, sedatives, nervines, foods, digestants, etc., which her husband, who seemed to have the most control of her, occasionally succeeded in coaxing her to swallow, but without any appreciable effect. I obtained the best results from the hypodermic injection of a third of a grain of morphine; but unfortunately they were only temporary. I tried to get some hyoscyamine, intending to use it in the same manner to the extent of one hundredth grain; but there was none to be had in the city, I am ashamed to say. I telegraphed to Chicago for it, but even in that great City of the West I failed to obtain it.

I remember to have used it successfully in a very aggravated case of chorea in a young married woman in a distant town where the attending physician, satisfied with having administered the prescribed remedies in the prescribed doses without effect, folded his arms and looked on as a mere passive spectator, leaving the case entirely to nature.

In the meantime my patient became exceedingly noisy and violent, having broken the sash of the window at the foot of her bed. Prior to this she was comparatively quiet; indeed at times she was unusually so. This, as we subsequently learned was for a purpose, illustrating the peculiar cunning of the acutely insane. She at times *pretended* to be asleep and when she thought her attendants

were dozing she made sly efforts to leave her bed and room. Occasionally she caught a word spoken by one of the nurses, when she immediately began to repeat it rapidly, even singing it at times, ever and anon breaking out in a familiar tune.

It had now come to be a desperate case. Her husband gave her up as hopelessly insane, and the friends began discussing the propriety of sending her to the State Asylum. It was time *something* was done, and done quickly. I was yet hopeful that if I could put her to *sleep*, and keep her asleep *continuously* for 24, 48 or 72 hours, she would awaken very much improved if not entirely rational.

I would then be satisfied at least that I had done my whole duty, or that a prolonged sleep would avail nothing. We were now entering into the 4th or 5th night, and the question was *how* to get her asleep. Two attendants were holding her in bed while she was alternately screaming, singing and making violent efforts to get away.

Now comes the most interesting, important and instructive part of the case, viz: its therapeutics, the effect of which, although not wholly unexpected, was surprisingly successful.

I had a desperate case before me, and resolved upon a corresponding course of treatment. Had my patient died, it is questionable if I should have reported the excessive dose I gave her; but she lived, and immediately improved, after the artificial sleep induced by nearly a whole grain of morphine injected into her arm, followed at once by chloroform inhalations. She slept until morning, when she awakened perfectly rational, took some nourishment and again went to sleep.

She thus slept and wakened for several days and nights, occasionally talking "a little off," as her husband expressed it; but on the whole constantly improving, although she remained very weak. I am quite certain she could have taken double the dose given, without serious toxic effects, in the condition she was in when I gave it to her.

It has been my experience in these cases that *small* doses only aggravate the condition we seek to control, and a tolerance for very large doses is established by the very nature of the case.

There are physicians who would no more exceed the dose recommended in the books, than they would cut off their own fingers.

It is right that we should have some standard, some rule of guidance, and some safe limit in posology; and the physician has

no business, perhaps, to violate on his own responsibility in a case of this kind such a limit in using toxic remedies. But one large, heroic, positive dose is worth a million small ones, which serve only to increase the trouble we are trying to relieve. There is much to learn yet in what may be called exceptional posology in exceptional cases. Circumstances alter cases; I believe it was the *size* of the dose that cured my patient.

REPORTS OF SOCIETIES.

THE SIXTEENTH CONGRESS OF GERMAN SURGEONS.

[Continued from p. 780.]

Sterilized Dressings.

DR. SCHLANGE, of Berlin, thinks that to insure an absolutely aseptic condition of the various materials for dressing wounds, it is best to sterilize them by exposure to a jet of steam at a temperature of at least 100° C. (212° F.)

PROF. VON VOLKMANN, of Halle, does not see any necessity for such procedure. It is well-known that bacteria will colonize under the best antiseptic dressings, and it is impossible to kill every single coccus. The human body is not a test-tube, but it has a certain power of resistance against cocci, and therefore it is sufficient if the surgeon has *clean hands*, uses *clean instruments*, and sees that the wound and its surroundings are *thoroughly disinfected*. On this iodoform-gauze is packed, and covered with moss or some other *desiccating* material. No tissue impermeable to fluids, such as rubber-tissue or mackintosh, should be interposed, for these favor the development of micro-organisms. Dry dressings will promote healing with absolute certainty by reducing the number of bacteria and the poisonous ptomaines produced by them.

PROF. VON BERGMANN, of Berlin, prefers to use sterilized dressings because they protect the wound from microbes, which give rise to infection by direct migration, e.g. erysipelas.

VOLKMANN mentioned the fact that among other cases, he has treated more than 300 cases of compound fracture without any death or any case of erysipelas.

BERGMANN thinks that this is no proof that such infection is *impossible*.

DR. LIEFFLER, of the Imperial Sanitary Board at Berlin, has found that the material used for antiseptic dressings—stored away in great masses for an emergency by the direction of the army officials—is as good as ab-

solutely sterilized if the middle of the packages is taken as a test. Only the most external layers of these compressed packages occasionally contains a few germs capable of being developed.

Value of Iodoform as an Antiseptic.

DR. DE RUYTER, of Berlin, has made some experiments in conjunction with Dr. Bearing to disprove the attacks made by Drs. Heyn and Rovsing, of Copenhagen, on the utility of iodoform as a dressing for wounds. He admits every thing that has been alleged as far as iodoform, as a *dry powder*, is concerned; but he has shown that in the secretion of wounds the drug is always decomposed, and a certain chemical combination is formed between iodine and albuminoids in the secretion, and especially the ptomaines produced by bacteria. In sterilized blood iodoform remains unchanged.

That the decomposition of iodoform is produced by the ptomaines, which in turn are rendered innocuous by the chemical combination thus engendered, is apparently paradoxical; yet, the incomparably beneficial and unprecedentedly reliable action of iodoform is without doubt due to this peculiar property, that it is only active when decomposed by the secretions of the human body.

It must be remembered that solutions of the element (iodine) itself in similar proportions have not been found to act as well as solutions of iodoform of the same strength. The best action is secured by a solution of iodoform, in alcohol and ether, which is the most rapid means to sterilize dressings.

In the discussion: PROF. VON VOLKMANN stated that he felt glad to see iodoform vindicated. The results published by the Copenhagen investigators were so diametrically opposed to all surgical experience that such vindication was sure to come, and he was glad it had come.

DR. SANGER, of Magedburg, corroborated the findings of Drs. De Ruyter and Behring by relating his experience, showing that even the poison of anthrax is destroyed by continued action of iodoform on the pathogenic bacillus. In his opinion it is the decomposition of the iodoform, which favors this germicide action. In wounds, primarily made aseptic, iodoform does all that is claimed for it.

PROF. BRUNS, of Tübingen, reported the favorable results he has obtained by injecting iodoform solution (10 per cent. in glycerin and alcohol) into all kinds of cold (tuberculous) abscesses. He has found that of 54 patients 40 were cured and the microscopical

examination of the walls of the abscesses by Prof. Nauwerck showed that the tubercles are arrested in their growth, the bacilli disappear, and the infectious walls of the abscess necrose, or undergo fatty degeneration, by the establishment of normal vascular granulations. The action of iodoform Prof. Bruns therefore designates as *specific and antibacillar*.

Transplantation of Skin.

DR. WAGNER, of Koenigshuette, illustrated the covering of defects on the arms by using portions from the skin over the thorax, by a case of extensive burns on the arm and forearm of a patient. He gives the rules laid down by the late Prof. Maas:

1. The thorax and arm must be immobilized with plaster of Paris dressing.
2. The superficial granulations on the part to be covered must be pretty deeply removed.
3. The flap to be used must be dissected off, following closely the distribution of the vessels, even if a decided turn has to be given to the base of the flap.
4. The flap must be stitched very accurately to the margin of the defect, and it may be approximated closely to the granulating surface by a few deep sutures.
5. A thick layer of boracic acid ointment ought to protect the exposed portions of the flap from becoming necrotic through desiccation.
6. The base of the flap ought to be divided in from ten to fourteen days.

He presented some patients on whom he operated in accordance with these rules with excellent result.

One of these was a laborer who had had the skin taken almost entirely off from his right arm. Two transplantations were made, first from the right and then from the left side of the thorax; the first about four months after the injury, the second about six months later. The result was very gratifying. Sensibility was acquired in the arm almost fully; but even mobility was restored to a limited extent, although there had been a fearful loss of muscle substance. His experience in this and similar cases leads him to consider careful suturing of the flap to the margins of the wound unnecessary, close apposition to the granulating surface being much more important.

WAGNER thinks that this method of transplanting skin is a great achievement in plastic surgery, and points to various conditions heretofore deemed almost incurable, such as large old ulcers of the leg, etc.

Prof. HELFERICH, of Greiswald, reported a case similar to those of Wagner; he has,

however, followed the advice of Prof. Thiersch, and studded the fresh granulating surface with small pieces of epidermis.

One point of importance is to protect the base of the flap from pressure which might endanger circulation.

Dr. HANS SCHMID, of Stettin, advises an early operation in these cases, especially when joints are implicated, as he has had a case in point. It is the best means to insure the greatest possible mobility of the limb.

Uranoplasty and Staphylorrhaphy in Early Infancy

was advocated by Prof. WOLFF, of Berlin. He has operated during the last two years on 24 cases of cleft-palate, 14 of the patients being below five years of age. In a very few cases only a second operation was necessary, and the condition of his little patients was invariably excellent, and remained so throughout the whole treatment. These favorable results Wolff ascribes to his methodical practice of using wound compression; and, in the after treatment, copious irrigations of the parts while the patient's head is hanging down over the end of the table.

In addition, in the majority of his cases he never made use of an obturator, and then only for a time. The speech in almost all the cases is very distinct, and has a normal and agreeable *timbre*, nearly all the nasal twang disappearing. He was able to present a half dozen of his patients, the youngest being 15 months, the oldest 8 years old. The earlier the surgeon ventures to operate, the better are the results, especially as to speech.

[To be concluded.]

Treatment of Syphilis.

In the discussion of the general treatment of syphilis by the Paris *Société Médicale des Hôpitaux*, M. Martineau gave a resumé of his practice, as follows: "This virulent constitutional affection should be treated in three ways: 1, with Mercury; 2, with Iodine; 3, with Sulphur. As regards the mercurial treatment, M. Martineau greatly preferred the cutaneous, and particularly the hypodermic method of its introduction. He employed a mercuric ammoniacal peptone (formula of Delpech) containing ten milligrammes of the sublimate. M. Martineau has made not less than 180,000 injections since 1881. There is nothing whatever objectionable in the method employed; the action is quick and most efficacious. The injections are made in the

back and may be given every two or three days. After a month of this treatment M. Martineau, for another month, gives by the stomach, daily, a teaspoonful of ammoniacal peptone (equivalent to five milligrammes of the sublimate). This method has great advantages over that of the injection of insoluble salts. The explanation of the method of the use of sulphur was deferred until the next meeting."

Cremation by the Bourry System.

The cremation society at Zurich, Switzerland, one of the best organized associations in the world, has adopted the Bourry system, which is described as follows: "Like Siemens, Mr. Bourry allows only heated air to communicate with the body. In both systems the corpse burns directly; no flame is to be seen singeing the body, but it burns itself by the abundance of hot oxygen which surrounds it. Bourry uses carbonic acid gas, prepared in a coke regenerator, for heating the crematorium. During the process of cremation he uses mainly chimney gases for heating the air before it touches the corpse, which allows a more economical use of the heat. It is of great advantage that the chimney should be thirty-five feet high from the base of the cellar, so that it is fully covered up by the building. The ashes fall, without being touched, by an almost automatically working apparatus, into the urn. The dissolution of the body does not take place in the dark, unseen and uncontrolled, but the whole action is clear and open. Bourry and Venini place the crematorium, which has the shape of a sarcophagus, and which can be approached from all sides, in the midst of the hall in which the service is to take place. There is a little window on the back of the sarcophagus through which one can see the process of cremation, which is completed within one to one and one-half hours, without smell or smoke. The process is solemn and beautiful, and avoids every unæsthetic manipulation."—*The Sanitary News*, May 14, 1887.

—Prof. Tumas points out in *Vratch* that calomel has an antiseptic action on bile. He finds that bile, when mixed with calomel, will remain unchanged for several days at 59° F.; while a specimen unmixed with calomel became rapidly putrid and turned to a reddish color.

EDITORIAL DEPARTMENT.

PERISCOPE.

The Treatment of Epistaxis by Counter-Irritation Over the Hepatic Region.

In a letter to the *London Lancet*, Alexander Harkin, M.D., F.R.C.S., thus emphasizes the value of counter-irritation in epistaxis:

I was much pleased to observe in a letter from your Paris correspondent, dated April 27th, that at a recent meeting of the Academy of Medicine M. Verneuil read a communication upon the treatment of certain forms of epistaxis by counter-irritation over the region of the liver. In the first case related by M. Verneuil, quinine, ergotine, and digitalis had all been tried in vain. In the second, plugging had failed. The third had been the subject of chronic nephritis, with secondary affections of the heart and liver, and the cavity of the nose had been plugged without effect both with ergotine and the perchloride of iron. M. Verneuil's treatment, which was immediately and permanently effective, consisted in the application over the region of the liver of a large blister. M. Verneuil had at first thought that the method was entirely his own, but from bibliographical research it turned out that it had been anticipated to a certain extent by Galen, who says that large cupping glasses applied to the hypochondriac region arrest nasal hæmorrhage. To me it is very satisfactory to learn that a mode of treatment practised by myself successfully for many years, and reported in *The Lancet* of Oct. 30th, 1886, with cases in illustration, has also been advocated by so eminent an authority in Continental medicine, and as far as he was concerned, independently of any suggestion from another. I am quite sure that, in his case any more than my own, the dictum of Galen had nothing to do with its origination. It is of more importance that the remedy, which is undoubtedly of the utmost value, should be more generally adopted, especially when its application is urged not upon merely empirical grounds, but in accordance with accepted pathological teaching. That your correspondent did not appear to be aware of my previous pronouncement on the subject arose possibly from the fact that my publication did not take the form of a monograph with specific heading, but as a portion of a paper treating of congestion of the liver, and protesting against the impolitic interference

of modern surgery with the sanitary efforts of Nature when through the medium of hæmorrhage from the hæmorrhoidal veins or the mucous lining of the nostrils she endeavors to lessen the turgescence of an important viscus. In illustration of my views, I gave the particulars of a case of vicarious bleeding from the under lip, which arose immediately after the de-ligation of hæmorrhoidal tumors with excessive bleeding, ultimately cured by blistering over the liver; of a second example, in which dangerous and profuse hæmorrhage from piles was immediately cured by a similar remedy; and then, in pursuance of my theme, appended the cases of three young men suffering from epistaxis, who were instantly relieved by blistering over the hepatic region. A remarkable case, which occurred during the recent riots in Belfast will further illustrate the subject: While paying my morning visit to a straw lodge, temporary barracks improvised for the members of the Royal Irish Constabulary, and accompanied by one of the officers, I found one of the men in bed with a handkerchief saturated with blood, which had flowed from his nose during the greater part of the previous night. On satisfying myself of the nature of the illness, I painted the man freely with the liquor epispasticus over the region of the liver, prescribing no other remedy but rest in bed. On our revisiting the man next day, he informed us that from the moment the blister began to pain him the hæmorrhage declined, and left him altogether a short time after. To quote from my paper: "The frequent occurrence of epistaxis in youth is evidently due to the excitement and hyperæmic condition of the liver and digestive organs during the period of active growth and the constant demands upon its functional activity. The liver at this stage closely approximates to the condition in after-life, which is the causal factor in the development of piles, and as such is equally amenable to treatment in accordance with etiological principles; the derivative that cures the hæmorrhoidal flux as certainly puts an end to the epistaxis, the outcome of hepatic congestion."

Influence of Infused Beverages on Digestion.

Dr. James W. Fraser has studied experimentally the action of our common beverages on gastric and intestinal digestion. These are his conclusions:—(1) It is better not to eat most albuminoid food-stuffs at the

same time as infused beverages are taken, for it has been shown that their digestion will in most cases be retarded, though there are possibly exceptions. Absorption may be rendered more rapid, but there is a loss of nutritive substance. On the other hand, the digestion of starchy food appears to be assisted by tea and coffee; and gluten, the albuminoid of flour, is the principle least retarded in digestion by tea, and it only comes third with cocoa, while coffee has a much greater retarding action on it. From this it appears that bread is the natural accompaniment of tea and cocoa when used as the beverages at a meal. Perhaps the action of coffee is the reason why it is usually drunk alone or at breakfast—a meal which consists much of meat, and of meats (eggs and salt meats) which are not much retarded in digestion by coffee. (2) Eggs are the best form of animal food to be taken along with infused beverages. Apparently they are best lightly-boiled if tea, hard-boiled if coffee or cocoa, is the beverage. (3) The caseine of the milk and cream taken with the beverages is probably absorbed in a large degree from the stomach. (4) The butter used with bread undergoes digestion more slowly in presence of tea, but more quickly in presence of coffee or cocoa; that is, if the fats of butter are influenced in a similar way to oleine. (5) The use of coffee or cocoa as excipients for cod-liver oil, etc., appears not only to depend on their pronounced tastes, but also on their action in assisting the digestion of fats.—*Journal of Anat. and Physiol.*

Nasal Vertigo.

The following conclusions are drawn from an interesting work by Dr. Joal (du Mont Doré):

I. There exists a nasal vertigo, true vertigo, *a naso laeso*.

II. It belongs to the group of reflex vertigos, and should be classed with gastric, laryngeal, and uterine vertigo.

III. Irritation of the branches of the trigeminal innervating the mucous membrane of the turbinated bones and of the septum is the cause of vertigo and of other nasal neuroses.

IV. Irritation of the trigeminal passes through the medium of the spheno-palatine ganglion to the vaso-motor nerves, whence comes circumscribed anemia of the brain, with vertigo.

V. Vertigo is induced by the following causes: 1st. Nasal inflammation (due to odors, irritating vapors, snuff, and grasses, when flowering); 2d. Acute coryza; 3d.

Chronic catarrh, especially in its hypertrophic form; 4th. Polypi of the mucous membrane; 5th. Catarrh of the posterior nasal cavity.

VI. Vertigo is induced chiefly by nasal affections of apparently slight consequence.

VII. Nasal reflexes are most common with gouty subjects.

VIII. Vertigo may show itself alone or accompanied by other nervous phenomena: visual trouble, *muscae volitantes*, hemicrania, nausea, vomiting, nervous excitability, hypochondria, sluggishness of intellect, nightmare, spasmodic cough, dyspnoea, increased secretions, syncope, weak pulse, and pallor of the face.

IX. To form a diagnosis, it is necessary to examine the nasal fossa of the person suffering from vertigo.

X. Investigation of nasal vertigo will diminish the number of cases attributed to gout, rheumatism, anemia, congestion, as well as to cerebro-cardiac neuropathy.

XI. The vertigo will cease when the nasal affection to which it is due has been cured.

Santonate of Atropine.

The difficulty that is experienced in preserving solutions of atropine, owing to the formation of mucors which are highly objectionable in ophthalmic practice, has led M. Bourbelon to endeavor to obtain a stable compound. He believes he has accomplished this end in the employment of santonate of atropine, the solution of which produces no irritation when applied to the eye, whilst its power of dilating the pupil is the same as that of atropine sulphate. One drop of solution of atropine santonate containing 1 part in 2,000 of water dilates the pupil in six minutes, and the action is maintained for a period varying from ten to twenty-four hours. Atropine santonate has not been hitherto obtained in a crystalline state. It appears in the form of a white powder which has no hygroscopic properties. It is requisite to observe that the santonate and its solutions ought to be preserved in flasks of yellow glass, in order to avoid the action of light and the formation of photosantoninic acid. It may be borne in mind that a valuable suggestion was made some years ago by Dr. Aquila Smith for the preservation without deterioration of solutions of atropine, which consisted in using as a menstruum the camphor water of the Pharmacopoeia; the only objection to which is that it causes slight smarting when first introduced into the eye. This, however, soon passes off, and has not been attended, in any case hitherto observed, with troublesome consequences.

Innominate Aneurism—Ligation of Common Carotid and Sub-clavian Arteries—Recovery.

At a recent meeting of the College of Physicians of Philadelphia, D. H. R. Wharton reported a case of aneurism of the innominate artery, cured by distal ligation of the carotid and sub-clavian arteries. The patient was a man 42 years old, who came under Prof. Pepper's care, in the Hospital of the University of Pennsylvania, in November, 1886. After the diagnosis was established he was transferred from the medical to the surgical ward, and came under the care of Prof. Ashhurst. On Nov. 13, he was operated upon by Prof. Ashhurst, who cut down upon and ligated the right common carotid artery, just above the omohyoid muscle, with a strong cat-gut ligature. The right sub-clavian artery was next exposed and ligated in its third part, just outside the anterior scalenus muscle, with similar material. The wounds were closed with silver sutures, drainage tubes being introduced, and the wounds dressed with oiled lint. The whole right arm was wrapped in cotton, to maintain its temperature. There were no symptoms of disturbance of the cerebral circulation by the cutting off of the supply of blood from the right carotid artery. In a few days the aneurismal tumor was smaller and firmer, and its pulsations less forcible. The dysphagia and dyspnoea, of which the patient had complained, were also very much lessened. On January 13, 1887, two months after the operation, the patient was dismissed from the hospital.

Dr. Wharton reported that he had found the records of thirty-two cases of simultaneous double distal ligation of the right carotid and subclavian arteries for innominate aneurism, followed by recovery in twelve cases, death in sixteen cases, and temporary improvement in four cases.

The case reported, and operated on by Prof. Ashhurst, is one of the most brilliant of these cases, and fortifies the opinion expressed by him, that the method of simultaneous double distal ligation is preferable to the operation on one vessel at a time. In speaking of the manner of performing the operation, Prof. Ashhurst, and others who spoke after him, dwelt upon the importance of exposing as little of an artery as possible in ligating it.

The patient was shown at the meeting in a condition which was a remarkable contrast to that in which he was, immediately before he was operated upon.

The Uses of Sulphate of Sparteine in Cases of Morphine Habit.

M. Ball and Dr. Oscar Jennings, after considerable experience in severe cases, have found the best course of treatment for tiding over the difficulties of the time of the compulsory abandonment of the morphine is by hypodermic injection of sulphate of sparteine in doses of from one-sixth to one-third of a grain. This acts as an immediate cardiac stimulant. They do not find sudden and complete suppression of the use of morphine in such cases always advisable, but give some occasionally in dangerous collapse. They testify also to the usefulness of a few drops of a solution of nitro-glycerine put on the tongue as giving momentary relief in moments of crisis.—*The Practitioner*, June, 1887.

Treatment of Ophthalmic Headache.

Giles de la Tourette and P. Bloch, pupils of M. Charcot, have recently made known the views of their eminent master on this subject. Féré has already described the different forms which ophthalmic headache may assume. It differs clearly from other headaches by many symptoms which may be styled specific. Mr. Charcot admits of two varieties of ophthalmic headache—the one, simple, consists solely of pains in the head and visual disturbance; the other, "headache with complication," presents, in addition to the former symptoms, a transitory aphasia, more or less pronounced trouble of the sensory and motor nerves of the limbs and side of the face. In simple ophthalmic headache with transient amblyopia under the form of hemiopia and scintillant scotoma, the prognosis is favorable; the affection is annoying but not alarming. It is far different in the compound form; when aphasia supervenes, when the patient experiences formication on one side of the body and symptoms of paresis and even epileptiform attacks both he and those around him may well feel alarmed. If the crises are frequent he may be obliged to give up his occupation. Finally, it has even been found that each of the above cited symptoms—hemiopia, aphasia, sensory and motor disturbances—after having shown themselves ephemerally, may increase in duration or become chronic. It is therefore of service to learn that Charcot had obtained marked success by a bromide treatment applied in the following manner: The patient should be powerfully, continuously and for a long time, impressed. These important indications may be fulfilled

as follows: The patient is given 30 to 45 grains of bromide each day of the first week, 45 to 60 grains of bromide each day of the second week, 60 to 75 grains of bromide each day of the third week, 75 to 90 grains of bromide each day of the fourth week, and then re-commence the same series. According to the mitigation or otherwise of the attacks, diminish or augment in like ratio the doses; but the treatment should not be suspended before a complete and permanent cessation of all the phenomena occurs. The minimum duration of this treatment will never be less than three or four months.

Bisulphide of Carbon in Pulmonary Disease.

Wallace A. Briggs, M. D., writes as follows to the *Sacramento Medical Times*, July, 1887:

Carbon bisulphide, whose virtues in enteric fermentation Dujardin-Beaumetz has so highly extolled, has more recently come into extensive use in the treatment of chronic pulmonary troubles. It is not my purpose here to discuss the value of the remedy as much as to call attention to a simple and, I believe, efficacious method of its administration, viz.: that of Dujardin-Beaumetz in gastro-intestinal fermentation already referred to. In this way I have employed it for several weeks, and seemingly with all the advantages to be derived from gaseous rectal injections, which are certainly more troublesome to the physician and more repugnant to the patient. The formula I use is ordinarily the following:

B. Carbon bisulph. pur.....50 grms.
Aque menth. piper.....2000 c. c.

M. 1

This is to be thoroughly shaken and, after settling, is ready for use. Only a small part of the bisulphide will dissolve, and the bottle may be frequently replenished by filling it with mint, gaultheria, or whatever aromatic water is preferred, and thoroughly shaking and settling as at first. The dose is from two to six ounces, with an equal quantity of water or milk, four or five times a day. In one case of chronic bronchitis with bronchiectasis, a very marked improvement in cough, expectoration, and strength has been coincident with the use of this solution. Other cases of chronic pulmonary trouble, including one of chronic, or perhaps sub-acute, broncho-pneumonia, have seemingly been favorably influenced.

¹ [For all practical purposes this mixture is in the strength of one fluid ounce of bisulphide to the quart. Bisulphide of carbon, when freshly made and pure, is much less unpleasant than that ordinarily obtained. —EDS. REPORTER.]

Treatment of Whooping-Cough.

Cadet de Grassicourt states, that according to his experiments, *grindelia robusta* is not a specific in whooping-cough. Exhibited as an ethereal extract in doses of 20 to 50 drops a day, it may, in certain cases, diminish the number of paroxysms, and can be employed when other means have failed. M. Bilhaut had reported more satisfactory results but one must take into account in this species of inquiry differing circumstances which investigators too often neglect; such as whether the attack is mild or severe, and if the disease is in its early or more advanced stage. Syrup of narceia, recently advised by Labarde, painting the posterior fauces with cocaine, bromide of potassium, and breathing compressed air, are to be remembered as having been successfully employed. The advantages of change of residence in the decline of whooping-cough are conceded by everybody, and frequent change of rooms simply is often attended with good results. In this case it is advisable that the chambers of the invalid should each time be disinfected with sulphurous fumes. M. de Grassicourt does not think it advisable to permit whooping-cough patients to go out often at the acute period, particularly when less than three years old, for fear of broncho-pneumonia. How long whooping-cough is contagious is not decided; it is likely that contagion is possible so long as the paroxysms are clearly marked. The assertion of an authority in infantile pathology that whooping-cough is not contagious after the second month, when the cough persists, is debatable. It is probable that transmissibility ceases when the paroxysms are short and supervene at distant periods. But it is impossible to fix the precise date.

Napelline in Facial Neuralgia.

In a paper on napelline in facial neuralgia, M. Grognot adduces the following case by way of illustration. He states that he was called to see a young girl suffering from severe pain extending over the entire head, which felt, she said, "as if it were pressed in a vise." The pain, however, was greatest on the right side in the parietal and frontal regions, and immediately above and below the eye it attained its maximum intensity. There were no tears, but, according to the patient, there had been in previous attacks. The tongue was slightly coated, but there were no caries of the teeth on the side affected. The author prescribed one granule, containing $\frac{1}{2}$ grain of napelline, every two hours. On the first day the pa-

tient took ten granules; during the evening the pain disappeared. Although the pain had not returned the next morning, the patient was advised to take four granules and two the following day. Two months later the patient's neuralgia re-appeared, and she took eight granules. The next day he found the neuralgia had disappeared, and since that time the health of the patient has been excellent.

Napelline is an alkaloid, obtained from the *aconitum napellus*. An account of its chemistry appears in the *Pharmaceutical Journal* for 1872, p. 245. It is mentioned in the Supplement to Neale's "Digest." It is said to occur as an impurity in amorphous *aconitum*.

Tubercular Laryngitis.

M. Hering, of Warsaw, records twenty-nine cases of laryngeal tuberculosis treated by scraping. He divides these cases into three groups. 1st. Nine cases of tubercle in which after one year and three months the cicatrix remained healthy. 2nd. Nine cases of recurring tubercle, again treated by scraping, with three cures. 3rd. Six cases of ulceration of the nose, pharynx, and tongue. The general health was bad. In two cases there was partial cicatrization until the time of death.

REVIEWS AND BOOK NOTICES.

[Those sending Books for Review will oblige our readers by always stating publication price. In the case of Reprints, authors are requested to state the conditions upon which copies may be obtained by those of our readers interested in the subjects treated.]

NOTES ON CURRENT LITERATURE.

—The first edition of Mr. Christopher Heath's well-known "Dictionary of Surgery" has been exhausted, and a new edition is shortly to be issued.

—Dr. G. E. De Schweinitz, of Philadelphia, sends us a very interesting Series of Cases, illustrating various forms of hemianopsia and other irregularities of the field of vision. It is reprinted from the *Journal of Nervous and Mental Diseases*, May, 1887.

—"The Uses of Adhesive Plaster in Orthopædic Surgery" is discussed in a very clear and practical way by A. B. Judson, M. D., of New York. The pamphlet before us is reprinted from *The New York Medical Journal* of June 4, 1887.

—It is pleasing to our national pride to note that the only important German Dental

Journal (*The Journal für Zahnheilkunde*), is one published by a society of doctors of dental science who were graduated in America.

—A semi-romantic interest attaches to the medical activities of the Orient, and we are glad to welcome a new journal from Constantinople, *The Hospital Gazette of the Ottoman Empire*. The June number informs us that Zoëros Pacha has instituted a laboratory for antirabic inoculations, and is about to apply the method in the case of a boy aged fourteen.

BOOK NOTICES.

Practical Urine Testing. A Guide to Office and Bed-side Urine Analysis. By Charles Godwin Jennings, M. D., Professor of Chemistry and Diseases of Children, Detroit College of Medicine, etc. 16mo, pp. 124.

This is a handy volume, containing a brief statement of the constituents of normal urine and the substances found in disease of the genito-urinary apparatus, together with the various processes for qualitative and quantitative analysis. A number of cuts illustrate the sedimentary deposits which are found in the urine. Altogether, the book will prove helpful to those to whom it is addressed.

Transactions of the Texas State Medical Association. Annual Report of the Special Committee on Surgery, 1886. Compiled and edited by George Cupples, M.D., etc. Quarto, pp. 26.

This interesting report contains elaborate tables of the surgical work done in Texas during the year 1886. It was prepared after distributing 3,000 circulars asking for statistics throughout the State, to which sixty-six surgeons replied. The resulting report is creditable to the zeal and enterprise of the committee and to the skill of the surgeons of Texas.

The Diagnosis and Treatment of Hemorrhoids, etc. By Chas. B. Kelsey, M. D., Surgeon to St. Paul's Infirmary for Diseases of the Rectum, etc. 16mo, pp. 78. Detroit: George S. Davis, 1887. (The Physicians' Leisure Library, No. 1.)

This little paper-covered book is the first of a series of twelve small monographs, which are being published by Mr. George S. Davis, at the rate of \$2.50 a year, or twenty-five cents for a single number. If for this price the purchasers always get as valuable a production as that by Dr. Kelsey, we think they may be congratulated.

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N. A. RANDOLPH, M. D., } EDITORS.
 CHARLES W. DULLES, M. D., }

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TRUE CIRRHOSIS OF THE LIVER, VS. CARDIAC CIRRHOSIS.

The following points with reference to the so-called "nutmeg liver," now seem agreed upon by histologists.

It is the mottled appearance of the liver in certain stages of cardiac cirrhosis which gives it the name of nutmeg liver; the color is due to the mode of distribution of the blood.

At the onset of the lesion the hepatic gland presents nothing abnormal. At an advanced period the tissue becomes firmer and denser, the parenchyma is gorged with blood, and the blood-stasis continuing, the hepatic veins swell even to their capillaries. If at this period you take a section of the liver you see the nutmeg appearance above alluded to; there are dark spots corresponding to the dilated intra-lobular veins, and relatively clear spots corresponding to the compressed peri and interlobular veins, and green spots due to biliary stasis.

The hepatic tissue is more resistant than natural, but the lesions are not yet great, and the cells are still centres of an active nutrition. Soon, however, these cells are choked out by the distended veins and capillary net-work, and the atrophy, giving place to connective tissue and granules.

As the disease progresses, the connective

tissue contracts, and the liver diminishes in volume (atrophic stage of the nutmeg liver); then the organ takes a granular aspect. It is at this point of the disease that it is apt to be confounded with true cirrhosis. Cardiac cirrhosis, however, is a sort of soft atrophy, while true cirrhosis is a hard atrophy; in fact the cardiac liver never attains the consistency and firmness of true sclerosis. In the latter disease, moreover, the vascular distention begins with the periphery; while in the former it is the central venous radi-cles which are first affected, and the periph-ereal are involved only secondarily.

Cardiac cirrhosis at the onset consists of a circulatory trouble without lesion. Sclerosis is characterized by a development of connective tissue, which thickens and proliferates, forms adhesions, and contracts more in some places than in others, and gives a peculiar lobulated appearance to the liver. On section the liver is hard, sometimes even lardaceous, and creaks under the knife. There are numerous salient granulations between the thickened prolongation of Glisson's capsule; the tissue has a tawny yellow color; sometimes the section is clear and shiny.

The hepatic cells, normal in certain points, are destroyed or fatty in others. Little by little, owing to retraction of the cellular tissue, the glandular parachyma is choked out and destroyed.

HEROIC TREATMENT.

In this number we publish an interesting report of a case of acute mania, which was cured by the combined use of a hypodermic injection of morphia and chloroform inhalations. This is practically the method of "mixed narcosis," recommended some years ago by Prof. Nussbaum, for producing anesthesia in surgical operations. Nussbaum injected a quarter of a grain of morphia, about fifteen minutes before beginning the inhalation of chloroform. In this way he secured a quiet and prolonged narcosis with the use of a comparatively small quantity of the chloroform. The effect of the morphia was two-fold: it acted as a heart-tonic, counter-acting the depressing influence of the chloroform; and it prolonged the state of insensibility which the chloroform produced. The method has not secured universal adoption; but it is one of great value in tedious surgical operations, especially when chloroform is used instead of ether. It is also a very useful method to be employed in acute mania, or tetanus with convulsions, or in those cases of ideo-motor excitability, which are often mistaken for hydrophobia.

NEW TEST FOR WATERED MILK.

Szilasi, according to the *Lancet*, of June 11, has recently proposed a new test for pump-water in milk. It is based on the fact that sulphate of diphenylamine is colored blue by the action of an exceedingly dilute solution of a nitrate. As well water always contains more or less nitrates, its presence in milk can be detected. The test is thus carried out: Twenty minims of sulphate of diphenylamine is placed in a small porcelain vessel, and a few drops of the milk to be examined are added to it. If the milk contain even 5 per cent. of average well water a blue tinge will gradually distinctly appear. Sulphate of diphenylamine is very cheap, so the test may be readily tried.

ENGLISH DOCTORS DISAPPOINTED.

The profession in Great Britain is a trifle hurt at what it considers a slight in the relatively few titles conferred upon medical men at the Royal jubilee. No baronets at all were chosen from the medical ranks, and only three knighthoods were conferred. This may all be very well, and not really unimportant, but we think that the physicians of America are to be congratulated in that they are removed from the temptation of aspiring for tinsel. *The Medical Press and Circular* of June 29, 1887, says: "To us it seems rather a poor reward for a life largely spent in ministering to the sufferings of a gouty aristocracy to receive only a knighthood, and we are almost betrayed into a hope that some sharp in the near future will open the eyes of the responsible parties to the enormity of their conduct."

TREATMENT OF OZÆNA BY ANIMAL GRAFTING.

In a research upon "Animal Grafting with the Skin of the Frog, in Losses of Cutaneous and Mucous Substance," undertaken along with Dr. Dubousquet-Laborderie, Barataux publishes observations upon ozæna, atrophic rhinitis with ulcerations, in which he obtained a complete cure by engrafting the skin of a frog over the ulcerated surfaces. He has thus treated eleven patients having ozæna and ulcerated non-specific rhinitis. In all these subjects he employed ten to twenty grafts, of which more than half have succeeded, and all the patients have derived much benefit from the treatment. He has always succeeded in obtaining a smooth mucous membrane. He takes the frog's skin from the interdigital membrane, the nictitating membrane, the belly, the lateral parts, by scissors, and places upon the raw surface with forceps, or by a special pipette.

NOTES AND COMMENTS.

THE MODERN TREATMENT OF COMMON DISEASES.

Amenorrhea.

Chloride of ammonium (gr. ivss—gr. xv several times daily) is commended by Anstie and Cholmeley as an emmenagogue. As an emmenagogue and to relieve menstrual colic, Pitschaft recommends borax, though some doubt its efficacy:

R Boracis.
Aqueæ amygd. am..... aa 3 j
Aqueæ melissæ..... 3 iv
M.—A tablespoonful hourly.

A famous emmenagogue is the elixir proprietatis Paracelsi, composed of:

R Aloe.
Myrrh..... aa 3 ss
Croci *..... gr. xv
Spirit..... 3 v ð ij
Acid. sulphur. dil..... 3 ss

* [Trousseau says it is a fact of public notoriety that women engaged in picking saffron suffer from frequent attacks of uterine hemorrhage.]

The iodide of iron and saccharated iodide of iron are also widely used. Brera recommends a vaginal injection of water of ammonia, gtt 5—15 in 3 xv—3 iv of mucilage or milk. Kopp prescribes the following:

R Inf. summitat. sabinæ..... 3 vj 3 iij
Boracis 3 j
Sacch. alb. 3 vj
S.—One tablespoonful three times daily.

Tavignot's prescription is:

R Phosphori..... gr. iss
Ol. amygdal.
Ol. cacao aa 3 ij ———
Flor. malvæ pulv..... q. s. ad pil. [No. 100.
Sig.—4-6 pills twice or three times daily. [Dose too large.]

In suppression or retention of the menses, Fuchs gives:

R Ol. sabinæ 3 ss
Ol. terebinth. rectific. 3 viiss
M. S.—Apply to the inner surfaces of the thighs.

Lebert's formula is:

R Ol. sabinæ.
Ol. rutæ aa 3 ij
Sacch. albi 3 vijs
Dissolved in aqueæ dest. 3 v.
Add syr. sacch. 3 vijs
M. S.—One tablespoonful every two hours.

As an emmenagogue in chlorosis, Oesterlein advises:

R Myrrh.
Aloes.
Ferri pulv. aa 3 j
Extr. valerian. q. s. ut ft. pil. No. 100.
M. S.—Five pills three times daily.

Feller's emmenagogue is :

| | | |
|---|---------------------|----------|
| R | Myrrh..... | 3 jss |
| | Boracis..... | 3 ij |
| | Croci..... | gr. xxij |
| | Ol. caryophyll..... | 3 ij |

M.—Ft. chartas, No. viij.

S.—Two to three powders daily.

Sulphate of iron has also been found useful :

| | | |
|---|---------------------|-------------|
| R | Ferri sulph..... | gr. iij ¼ |
| | Rhiz. zingiber..... | gr. viij—xv |

M.—Ft. pulv., No. 10.

S.—One powder morning and evening.

Bacher's prescription is :

| | | |
|---|---|---------|
| R | Extr. hellebore..... | aa 3 ij |
| | Extr. myrrh..... | aa 3 ij |
| | Pulv. herb. card. benedict, q. s. ut ft. pil. 50. | |

S.—Two to three times daily.

Wolf gives :

| | | |
|---|-------------------------------|--------|
| R | Extr. colchici acid, e semin. | |
| | Aloes pulv..... | aa 3ss |
| | Ft. pil. No. xxx. | |

S.—One pill morning and evening.

Another recommendation of Oesterlein is :

| | | |
|---|--|-------------|
| R | Canthar. subt. pulv..... | gr. xv |
| | Ferri oxydat. fusc..... | |
| | Aloes..... | aa gr. xxij |
| | Extr. chamom., q. s. ut ft. pil. No. 50. | |

S.—One to two pills three times daily.

Radius advises the following in chlorotic amenorrhea :

| | | |
|---|--|--------|
| R | Aloes pulv..... | 3 ss—j |
| | Ferri pulv..... | 3 ij |
| | Rad. rhei pulv..... | 3 j |
| | Mucilag. tragac., q. s. ut ft. pil. 120. | |

S.—Two to three pills twice daily.

Ringer and Phillips say that sudden suppression of the catamenial flow, caused by cold, can be relieved by aconite in drop doses of the tincture every half-hour or hour. Bartholow says this remedy has a high degree of utility in congestive dysmenorrhea occurring in plethoric subjects. The same authority also says apiol is serviceable in the amenorrhea of functional inactivity and anæmia. The state of the blood and the constipation having been considered—give gr. xv at the time of the menstrual molimen, or just preceding the time when the flow should begin. Repeat daily in obstinate cases. Prof. Parvin also favors apiol. Eberle says (and Bartholow confirms the statement) that with polygonum hydropiperoides ("smart-weed") he has been more successful in amenorrhea than with any other remedy or mode of treatment. He gives m xxx of the fluid extract four times daily. When dependent upon atony of the ovaries and uterus, Bartholow says amenorrhea is cured either by static electricity, by faradism, or by the interrupted galvanic current : "A shock from a Leyden jar may be transmitted

through the pelvis, or a strong faradic or galvanic current may be applied by means of one pole on the spine, the other on the hypogastric region. In the case of married women, an insulated vaginal electrode may be introduced and placed in contact with the os uteri. This is a more effective way of making the applications than by the electrodes placed externally. In neuralgic dysmenorrhea, the galvanic current will afford relief in a large proportion of cases." J. C. Reeve, M. D. (*System of Medicine*—Pepper), says, "Electricity is the most reliable emmenagogue."

Treatment of Cholera Infantum in the Bellevue Hospital and New York German Dispensary.

Dr. A. Jacobi treats the cases which come into his ward, as follows :

INTERNAL MEDICATION.—*Empty the stomach and bowels* of fermenting masses. For this purpose castor oil answers well. A dose of calomel (grs. j-vj) answers better, because it acts as an anti-fermentative, beside being a purgative.

Neutralise acids (fat acids) in the stomach. Carbonate or phosphate of calcium, grs. j-ij, every one to two hours, acts as an adjuvant to other treatment. Bismuth also answers this indication, besides being an anti-fermentative. Dose, grs. ss-ij every one to two hours. May (must) be combined with opium, Dover's powder, grs. ½, ¼, or ⅓, every one, two, or four hours. No salts of magnesium or sodium, because they add to the diarrhœa in these acute cases. Avoid syrups to correct the taste of medicines. They will turn sour. Prefer glycerine.

*Anti-fermentatives.*¹—Calomel, bismuth, alcohol, creosote, salicylate of sodium, and resorcin have been recommended for their anti-fermentative effect. Of the two latter

¹ The practice of giving anti-fermentatives has preceded the theory for centuries. Still the theory is not quite so recent as a few modern journal articles appear to believe. In "Treatment of Infant Diarrhœa and Dysentery," by A. Jacobi, M.D., in *Amer. Journ. Obst.*, etc., July, 1879, there are the following remarks :

"A further indication is to destroy ferments. For that purpose most metallic preparations will do fair service. One of these is calomel . . . as to its effect as an anti-fermentative there can be no doubt. . . . Possibly, it acts by a portion of the drug being changed slowly into the bichloride of mercury."

"Alcohol certainly arrests fermentation."

"Sometimes, particularly when the stomach can be relied on, the salicylate of sodium may be added to the internal treatment. . . . The salicylic acid may prove beneficial, both by its anti-febrile and disinfectant action."

I prefer resorcin, iv-x grains, *a day*, in solution (suspension), or as a constituent of powders (with bismuth chalk opium).

Sedatives.—Opium diminishes hyperæsthesia, hyperperistalsis, and hypersecretion. Dover's powder (gr. $\frac{1}{8}$ to $\frac{1}{2}$ every two to three hours) acts very well, though some writers object to it, and is indispensable. Does well with bismuth, and prepared chalk, with or without resorcin.

Astringents.—In acute cases, and when the stomach participates in the process, lead, tannin, gallic acid, alum, etc., are badly borne. In chronic protracted cases they will find their indication. Nitrate of silver does better in many acute cases, gr. $\frac{1}{8}$ to $\frac{1}{4}$ in 2 drachms of distilled water (dark bottle) every two hours. Creosote water in chronic cases.

Stimulants.—Alcohol may be added to food. Bad brandy or whiskey contains fusel oil, which is a paralyzing agent. Whiskey is therefore preferable with us, because it can be obtained in greater purity for less money. (See under "Food.") Never give it raw. Camphor is better borne than ammonia. It is easily taken when simply rubbed off with glycerine suspended in mucilage (gr. $\frac{1}{4}$ —ij every one to two hours). The strongest nerve stimulant of all is *Siberian musk*. Give in *urgent* cases of collapse gr. i-ij every fifteen or thirty minutes (best suspended in mucilage) until six or twelve grains have been taken. A very good stimulant in collapse is the injection into the bowels through a long flexible tube (catheter No. 12) of hot water with some alcohol, and one or a few drops of tincture of opium.

EXTERNAL APPLICATIONS AND HYGIENE.—

In acute cases with high temperature applications of water of 60°–70° to abdomen. Where much pain and with anæmic children, warm applications do better. Frequent injections of water of 100° F. answer well in most cases, not only in rectal catarrh. In collapse of great debility, the water ought to be from 105° to 112° F., and contain some alcohol and opium. Part of this water will be absorbed, fill the blood vessels, and may prevent intracranial and other thromboses. The addition of gum-Arabic to the injection, or the use of glutinous decoctions (flax-seed) instead of water is quite satisfactory. Open doors and windows in hot weather. Select the coolest place in the neighborhood for the patient, day and night. Night air is better than no air. Country air, sea air, better than city air, particularly at some

altitude. When the body is warm and the weather hot, wash the body with cool water, or alcohol and water (1:5) frequently. Cold feet must be warmed artificially.

Food.—*No raw milk, no boiled milk, no milk admixture at all, in bad cases.* In vomiting and severe diarrhoea, *total abstinence* for from one to six hours. Afterward teaspoon doses of a mucilaginous or farinaceous decoction. Regular food: 5 ounces of barley-water, 1–2 drachm of brandy or whiskey, the white of an egg, salt and sugar, teaspoonful every five or fifteen minutes, according to age and case. May be mixed with mutton broth, which, with white of egg, etc., is better than beef soup or beef-tea in convalescence. Abstinence better for vomiting than ice; the latter may quiet the stomach, feel pleasant, but stimulates peristalsis. Avoid beef-tea. If it be given in convalescence, mix it with barley-water.

Toward the end of the disease, or when the discharges are many and copious, and inspissation of blood, and thromboses (hydrocephaloid) threatening, the common sense of the practitioner will introduce liquid into the circulation as best he can. No written rule ever supplies or substitutes brains.

At the New York German Dispensary, Dr. Augustus Caillé varies the treatment with the period at which the child comes under observation. Inasmuch as a simple dyspeptic diarrhoea may develop into the most violent choleraic diarrhoea through the agency of high temperature and improper feeding, it will be well to consider briefly the prophylaxis of cholera infantum—*i. e.*, the treatment of gastric catarrh, with tendency to diarrhoea. The diet of the sick child must be at once restricted. Food should be withheld for a period of from six to twelve hours, and water given *ad libitum*, also oatmeal, barley, toast-water, and lime-water. Nursing babies can be deprived of the breast for the same length of time.

The bowels should be evacuated by means of castor oil, magnesia cum rheo, or calomel gr. $\frac{1}{2}$, sugar gr. v, pro dosi, given every hour until five are taken. It is best to place the powder dry upon the tongue. If the tongue remains coated twenty-four hours after the administration of calomel, etc., dilute hydrochloric acid, with or without pepsin is indicated.

R. Acid. muriat. dil. gtt. xl
Aque 3 ijs
Pepsini pur. 3 ss
Syrupi simp. 3 iv

M.

Sig.—Teaspoonful every hour.

R Acid. muriat. dil. 3 ss
 Aquæ 3 xiv
 Tincture opii gtt. ij
 Syrupi simp. 3 ij

M.

Sig.—Teaspoonful every two hours.

In acid dyspepsia, alkalies (mist. cretæ) are indicated.

In order to save time and prevent misunderstanding, Dr. Caillé has found it a good plan to have a diet-card printed, which he presents to the parents, telling them to give to the sick child the articles of diet which are not crossed out. The articles enumerated on the cards are as follows:

Barley-water, oatmeal-water, white of egg in water, gum Arabic in water, lime-water, whiskey in water, bread crust boiled in water and allowed to cool, milk with any of the above waters, meat broth with any of the above waters, cold tea.

The acute attack (cholera infantum) calls for the following treatment:

1. Anti-fermentative (antiseptic) measures.
2. Rest for the intestinal tract.
3. Stimulation and prevention of collapse.

If a child is seen early, before collapse has set in, it should be kept as quiet as possible, and no food given for six to ten hours, on account of irritability of stomach. Pounded ice, with or without whiskey, cold tea, ice tied in a rag to be held in the mouth, are advisable; also, lime-water, toast-water, rice-water.

To meet indications 1 and 2 he relies upon the following drugs:

R Bismuth, subcarb. 3 j
 Aquæ cinnam. 3 ij
 Tinct. opii gtt. ij

M.

Sig.—Teaspoonful every one to two hours.

Or,

R Sodii benzoatis 3 j
 Aquæ 3 xiv
 Syrupi 3 ij

M.

Sig.—Teaspoonful every two hours.

Or,

R Acid. carbol. pur. gtt. ij ad vj
 Mucilaginis 3 ij

M.

Sig.—Teaspoonful every two hours.

Or,

R Argenti nitratis gr. ij
 Aquæ destil. 3 ij

M.

Sig.—Teaspoonful every two hours.

Or,

Resorcin gr. ij
 Aquæ cinnamoni 3 ij
 Tinct. opii gr. ij

Sig.—Teaspoonful every two hours.

He avoids the addition of syrup to a mixture, if possible, and omits the opium if the

patient apparently has little or no pain.

When children are very restless, and show by their actions that they suffer pain, he does not hesitate to give small doses of opium, one, two, or three drops in a two-ounce mixture.

A towel wrung out of cold water and secured over the abdomen, appears to relieve pain; and a warm mustard bath stimulates in impending collapse.

For obstinate vomiting he frequently gives:

R Tr. iodin. gtt. xv
 Aquæ menthæ 3 j

S.—15 π every hour.

A change of air is of the utmost importance. Children taken from a hot tenement to the seashore, or any cool, shady place, improve perceptibly in a short time, if not too far collapsed.

Large enemata of tepid water, with or without the addition of some antiseptic drug (acid. salicyl.), should be tried in obstinate cases, but in dispensary practice this method cannot well be carried out.

Stimulation must not be delayed until symptoms of collapse are marked. Young children with high temperature, cold and clammy feet and hands, and a pulse too rapid to be counted, are frequently stimulated in vain. The best stimulants, in his experience, are:

R Camphoræ gr. $\frac{1}{4}$
 Sacchar. gr. vj

Every three hours.

R Camphoræ gr. $\frac{1}{4}$
 Pulv. doveri gr. $\frac{1}{8}$

Every two hours.

R Camphoræ gr. j
 Bismuthi gr. vj

Every two hours.

If the children vomit the drug, it will be necessary to give camphor in ether, or camphor, caffeine, and ether hypodermatically.

In the dispensary practice children cannot be seen oftener than once every other day, or every day at the utmost; it is, therefore, a good plan to prescribe anti-fermentative medicine and camphor powders at one consultation, and direct the parent to give the powder after the medicine has been taken.

During the period of convalescence, astringents are indicated to combat the intestinal catarrh, such as tannic acid, acetate of lead, with or without opium. To guard against relapse, it is of the utmost importance to select the proper food for children deprived of the breast. In the majority of cases milk and oatmeal or barley gruel, in different proportions, according to age, with a pinch of salt, some sugar, and, if necessary, lime-water, will be the proper food for a child up to twelve months. This food has

been repeatedly recommended by Prof. A. Jacobi for the past twenty-five years. If it fails, others should be tried. Dr. Caillé has had good results from the employment of the so-called "peptogenic milk powder," and one or two other preparations recently introduced."—*Medical News*, July 9, 1887.

A Curious Effect Produced by Creosote.

I met a patient of mine a few days ago, and was astonished to find that he had become quite gray since I had previously seen him, a week before. I asked him did he know the reason of this sudden change? and his reply was: "I told everybody it was a fright I got, but I will tell you the truth. On last Friday I was going to a dance, and I put on my hair what I believed to be hair-oil. My scalp tingled and pained me frightfully. I thought no more of it then, but next morning my hair was beginning to get gray, and every day since it was getting more gray. It was creosote that was in the bottle, and not hair-oil." This man is about thirty-five years of age; he is the youngest of a family of five. The other members of his family have the same colored hair they had twenty years ago.—Dr. C. J. Kelly, in the *Provinc. Med. Jour.*, May 2, 1887.

Hydrochloric Acid for Dyspepsia.

Dr. Talma has employed with advantage, hydrochloric acid in the proportion of 15 minims to half a fluid-ounce of water, for dyspepsia. This is the strength for adults. The solution should be made lukewarm, and taken in small quantities in the twenty-four hours. The best effects are produced, when the remedy is taken after each meal. Fat should be excluded from the diet. Contrary to precedent, Talma does not prescribe milk for chronic catarrh, nor for ulcer or cancer of the stomach. Hydrochloric acid not only prevents the fermentation of the contents of the stomach, but also by its antiseptic action has a beneficial influence on the coats of that organ. In nervous patients, or those showing a peculiar susceptibility to the action of hydrochloric acid, Dr. Talma begins by employing alkalies before administering the acid. In a series of cases, in which dyspepsia was caused by cerebral anemia, as in pregnant women, Dr. Talma has obtained good results by the employment of nitroglycerine in doses of 1 milligramme in the twenty-four hours. Trousseau long ago prescribed hydrochloric acid in the treatment of dyspepsia, and many special methods owe their success to the presence of this acid.—*Jour. of Amer. Med. Ass'n*.

A Case of Tetanus Cured by Hypodermic Injections of Cocaine.

Dr. M. Lopez reports the following case in *El Genio Medico-Quirurgico* for February 7, 1887: M. G., 50, laborer, after working in the wet and cold, complained of rheumatic pains of back and limbs. Three days later, he had marked opisthotonus and painful cramps, and all the symptoms of idiopathic tetanus. Chloral hydrate and morphine were prescribed. For three days the patient was kept under the influence of these drugs, with the result that the pain was lessened, but the muscular rigidity and cramps increased. He now became unable to swallow, and death seemed imminent. Morphine was injected hypodermically, but was followed by no amelioration of the symptoms. Three syringefuls of the mixed solutions of morphine and cocaine (each five per cent.) were then injected. The effect was immediate. After two hours, he could move the limbs, turn in bed, and open his mouth. On the next day he was going on well; slight trismus and stiffness of the neck remained. On both sides of the neck, and at the angle of the jaw, a fourth part of the syringeful of the same solution was injected. On the next day, all the symptoms had disappeared. The patient rapidly regained strength, and in a week's time returned to work.—*London Medical Record*.

The Treatment of Gleet.

Dr. Fred. A. A. Smith writes as follows in the *British Medical Journal* of June 18, 1887: Some years ago, a captain in the army consulted me about a gleet he had had for a long time. Nothing seemed to do him any good; at the same time he was anything but a temperate man, and, practically, was a very bad subject for treatment. I ordered him an ordinary alum lotion to be used as an injection, and for medicine: acid nit. dil., $\mathfrak{m}\text{xv}$; dec. cinchonæ flav., $\mathfrak{f}\mathfrak{3j}$, t. d. Returning home from his club in the evening, he took by mistake a dose of the alum lotion, and used the acid mist. as an injection. The consequence was that he suffered great pain for over an hour, but cured his gleet. Noting this, I tried on my next case: acid nit. dil., $\mathfrak{m}\text{v}$; dec. cinchonæ flav., $\mathfrak{f}\mathfrak{3j}$ as an injection t. d., and found my patient got rapidly well. I have since used this treatment in several cases with very happy results. Although constitutional treatment is no doubt very useful, still I am inclined to think that the disease is essentially local, and requires local remedies.

Common Errors in the Treatment of Skin Diseases.

Dr. George H. Fox, of New York, read a paper on this subject before the Montreal Medico-Chirurgical Society. The great error made by practitioners in treating skin diseases, he said, is failure to treat the patient: the disease is treated, not the patient. He considered attention to diet as most important. There should be a radical change both in the quantity and quality of the food. A dietary should be given the patient. The majority of the patients improve on starvation diet. He advised his patients to increase the quantity of fluids, and decrease the solids; to eat less and to exercise more. He gets the best therapeutical results from a vegetable diet in the treatment of inflammatory skin diseases: a meat diet congests the skin, a vegetable diet lessens congestion. He is in the habit of restricting meat in winter, and forbidding it in summer. In giving directions to patients, it is better to tell them exactly what to eat, instead of what to avoid. Water should be taken sparingly with meals, and in quantity after meals. Of local applications very few are needed. Arsenic, Dr. Fox said, is used too much by general practitioners in the treatment of skin diseases, and is a much overrated remedy.

The Treatment of Internal Hæmorrhoids by Injection.

Dr. Q. A. Shuford, of Tyler, Tex., sends the following communication to the *Medical Record* of June 25, 1887: "In the treatment of internal hæmorrhoids by submucous injection, it is necessary, in the first place, to have an instrument that can be introduced with the least amount of pain, and so constructed as to expose as much of the mucous membrane as possible. When a tumor is discovered, the speculum should be manipulated so as to bring the centre of the tumor into plain view, and the needle should have a guard near the point, so as to prevent it from entering too deeply. For small tumors I inject from three to five drops, and for larger ones from five to eight drops of the following mixture: Rub well together one drachm of salicylic acid and one and one-half drachms of glycerine, and add two drachms of carbolic acid; then rub together one drachm of borax and one and one-half drachm of glycerine, and mix the two thoroughly, allowing the mixture to stand until clear. The chemical changes and *modus operandi* of this combination I do not know; but I do know that internal hæmorrhoids treated in this way become atrophied, shrink

up, and peel off without pain, inflammation, or suppuration. I have never had any trouble nor heard any complaints from patients so treated. The two essential points in the treatment of internal hæmorrhoids are: first, an instrument that will bring the parts to be treated into view, and that without pain; and, second, a remedy that will completely destroy the pile, while leaving the mucous membrane in a healthy condition. An interval of from eight to ten days should be allowed to elapse between the injections, so as give the mucous membrane time to become toughened. The injections cause almost no pain, and do not prevent the patient from pursuing his ordinary avocations." Dr. Shuford reports several cases treated after this method, and adds that he has treated nearly one hundred, of varying degrees of severity, and in none has he seen any inflammation or suppuration following the injections.

Warm Ether as an Anæsthetic.

Dr. M. W. Hobbes advocates, in the Cincinnati *Lancet-Clinic*, the advantage of warming ether previous to its administration in the production of anæsthesia. He and Dr. Taylor have tried the method in upward of thirty cases, and he writes that the patients not only came under the influence of the drug more readily, but they also recovered more rapidly and pleasantly from the anæsthesia than patients generally do who have been brought under its influence in the ordinary way of administering ether cold.

Sedative Compound.

The following formula is commended by J. S. Dorset, M. D., Superintendent Texas State Lunatic Asylum:

| | |
|----|---------------------------------|
| M. | Hyoscine hydrobromate, 1-50 gr. |
| | Paraldehyde |
| | Oil almond..... aa. 2 dr. |
| | Chloroform..... 10 m. |
| | Oil cinnamon 2 m. |

M.

This medicine given at bed-time in drachm doses, in a great number of cases, is all that is necessary to secure a quiet, refreshing night's rest. The patients are not so nervous the next morning and are ready to take a good breakfast. He submits this formula to the superintendents of lunatic asylums for a fair trial, as a substitute for the chloral, which we feel is not good for the already diseased brain of a lunatic. He states that it is of especial value in wild, noisy cases, when sleep cannot be induced without much danger.—*Texas Courier Record*, June, 1886.

CORRESPONDENCE.

Improvements in Leg Holders.

The following interesting correspondence is self-explanatory. Incidentally it illustrates the value of the REPORTER as a medium for the interchange of practical ideas by practical physicians.—EDITORS OF THE REPORTER.

DR. THOS. B. MCBRIDE:

Dear Doctor:—IN THE MEDICAL AND SURGICAL REPORTER for June 4th., I notice a cut and description of your apparatus; or what some authors have termed a Gynæpod.

By some strange coincidence our thoughts bent on the same object, have brought us to almost identically the same result; and as I was interested in the description of your appliance, thought that possibly you might be in mine, so take the liberty of writing you. Two years ago next October I brought my class in Gynæcology the apparatus that I was then using, and had made myself; which consisted of a straight hickory rod which was passed under the knees, and fastened around the neck by a band of webbing similar to yours. My objection to this appliance was that it required a little too long time to disengage, should emergency arise, and had to be carried as a separate bundle, and the less appearance of paraphernalia brought into the sick room the better the effect upon the patient. I set about to improve it, and a year ago had made the apparatus which a number of physicians in this city are now using. The principle is the same, the rod passing under the knees, instead of being of wood, is of iron tubing, nickle-plated, bent at each end, as in your cut; in the centre is a hinge which allows it to be folded together when not in use; the buckles for regulating the length of webbing are at juncture of webbing with strap; at the extremity of each strap is a steel snap which clasps into a ring at each end of horizontal rod, which may be unclasped in less than a second if necessary.

To the left end is a little appliance in which to insert, when wanted, an upright rod with hook at top to hang a fountain syringe to, for irrigation, (or, as I frequently apply it, for checking hemorrhage by hot water); a Sim's speculum may be held in place by an elastic band from centre of horizontal bar. The whole apparatus fountain, syringe and all, I carry in my hand bag with the other instruments.

Yours cordially,

JOSEPH HAVEN.

Chicago, Ill., June 13th, 1887.

PROF. JOS. HAVEN, M. D.:

Dear Doctor: Your favor of the 13th duly received. As you say, it is by a strange coincidence we should both have centred our thoughts on the one idea and the outcome be so closely allied. When I showed my apparatus quite a number expressed surprise that it had not been thought of before, as it was so simple. But now I have to yield that you have had your invention in use before I even thought of mine, as it was only last January I had the first made. I must concede also that you have added to the utility of yours by the several improvements mentioned. The idea of a hinge was suggested to me by a number of physicians, and it has been added since about May 1. The cuts published do not show this, as they were made from my original apparatus. Another change was made by adding to the length of the ends of the semi-circles, making them extend from one to two inches above the level of the shaft. Again: The arrangement by which your apparatus is fastened is superior to mine, but I find no trouble in disengaging it by simply lifting the thigh out of the crutch. I take the liberty of handing your letter to the Editors of the MEDICAL AND SURGICAL REPORTER for publication, as this is about all the benefit we, as physicians, derive from being inventors. In fact, doctor, I am out of pocket and lost considerable time, in getting my appliance to its present imperfect state. I am, very truly yours,

THOS. B. MCBRIDE.

2022 E. Susquehanna ave., Phila.

July 25, 1887.

Homœopathy.

EDITORS MED. AND SURG. REPORTER:

Sirs:—I notice on page 34, volume lvii., No. 1, July 2, 1887, of your paper a note headed, "Homœopathy as it is." Please allow me to make a few comments upon it.

The *Medical Times* is not and never has been a homœopathic journal: it is of the worst type of *mongrel*. It is too true that it is almost impossible to find a teacher of homœopathy in our so-called Homœopathic Medical Colleges,—this is the reason why there is such dense ignorance of what homœopathy is among medical men at large, and why it is almost impossible to find homœopathic physicians who are truly such under the age of 35 or 40 years.

Unprincipled and ignorant men who do not know the first principles of the law of cure, claim the name and shout for it because they know it "pays;" and their "broad

and liberal" methods and principles are the strongest proofs of their ignorance and laziness.

"High-dilution homœopathy" is a misnomer—there are no "high dilutions." The educated homœopath never uses the word "dilution:" that is the stamp of ignorance of the fundamental principles.

Please do not advocate the teaching of pseudo-homœopathy of the Allen, Hughes and Dudgeon stripe in colleges. But if you would seek to elevate the medical profession, or give it a knowledge of what homœopathy is, let the Organon of Samuel Hahnemann be taught by a competent teacher who knows and understands it *himself*, and you may rest assured that "we" most emphatically "*do* hold that homœopathy is the exclusive and only law of healing."

H. HITCHCOCK, M. D.

Newark, N. J., July 6, 1887.

[The above letter was sent with an urgent request to publish it in the interest of fairness. We do so with pleasure, as we desire that everyone who is concerned in such a discussion shall have a chance to present his views in a fair and temperate way. Of course we do not thereby endorse the views of our correspondent.

—EDS. OF THE REPORTER.]

Fees of Veterinarians.

EDS. MED. AND SURG. REPORTER:

Please see page 767, No. 24, 1887, MEDICAL AND SURGICAL REPORTER, and note what is said about the remuneration of veterinary surgeons.

Allow me to say that the paragraph in question is calculated to cruelly deceive young men who may incline to the idea of becoming veterinary surgeons.

From personal observation in a number of Western States, I must say that it is a rare exception for a veterinary surgeon to collect \$100 per month, and many do not collect half so much for purely professional work, and are *forced* to give some attention to other matters in order to secure a living. Doubtless, in *some* of the Eastern States, veterinary surgeons are better paid; but, in the West, such men, now, are *pioneers*, and must submit to a pioneer's lot or quit the profession.

Of course I do not refer to *irregulars*, but "regular" graduates of first class veterinary colleges.

Fraternally yours, J. C. SMITH.

Austin, Texas, June 17, 1887.

"Sweet Are the Uses of Adversity."

An esteemed and philosophical correspondent in another State sends us, without comment, the following jotting:

"It occurs to me that the poverty of physicians, which is proverbial, is simply in accord with Divine or Natural economy. The physician who becomes financially independent becomes less valuable to the community in which he resides. In proportion as he increases in wealth does he decrease in importance as a physician. Few practitioners would bear the ills and perplexities of their practice if situated so as to live independent of it. There are, however, wealthy specialists whose practice continues to be lucrative and not as annoying as that of the general practitioner, who find it pleasant and profitable enough, to keep abreast with the progress of their specialty."

NEWS AND MISCELLANY.

A Clergyman on the "Faith Cure."

In a recent sermon on this subject, Rev. E. C. Ray, of Hyde Park, Ill., says: "Apparent cures are often followed by a relapse, temporary improvement by permanent decline. From reported cases of cure we must deduct many of unreported relapse: it is not in human nature, when a wonderful cure has been published abroad, to follow it up with an account of the relapse coming afterward. Mistaken diagnosis accounts for many supposed cures. Physicians often, patients more often, mistake the nature of a disease. Temporary swellings are called malignant tumors or cancers (thus cancer-doctors get their reputations); hysteria simulates almost every other disease, so as to deceive even the most elect of doctors; dyspepsia produces symptoms of heart-disease or other deadly illness. There can be no question that a large proportion of faith-cures and mind-cures, and a considerable proportion of cases under ordinary medical treatment, are cases of mistaken diagnosis, the disease being less serious in its nature than was supposed. Mistaken prognosis accounts for many cases; mistake as to what would be the outcome of the disease if no curative methods were employed. It is a truth seldom recognized by patients, though well known to physicians, that in most cases not hopelessly fatal from the start, there is from the start a strong tendency toward recovery. Dr. Austin Flint, Sr., than whom perhaps no abler physician has lived in this land, always urged upon his students the truth

that not drugs, but *vis medicatrix natura*, the healing-power of nature, is the means of recovery. The wise physician and nurse seldom attempt more than gently and humbly to assist Nature in her curative processes. Let me add the statement of a conviction derived from some years of such close scrutiny of medical practice of various schools as a pastor has good opportunity for,—a conviction agreed to, I think, by most physicians:—The benefit of medicine is often not its direct action upon the disease or upon the body, but its action upon the mind, and through that upon the nervous system and the whole body, stimulating faith, hope, expectation of recovery, good cheer, which are probably nature's mightiest remedial assistants."

Transplantation of the Cornea.

Dr. T. Webster Fox, of Philadelphia, sailed Wednesday last to visit the clinic of Von Hippel, who has recently succeeded in transplanting the cornea of the chicken upon the human subject in three cases of corneal leucoma. A full report upon this operation, together with Dr. Fox's own experiments, will be published in an early number of the *REPORTER*.

Hygienic Handwriting.

Schubert, of Nuremberg, has made a careful study of various kinds of script, and the bearing which the use of each has upon the hygiene of the eyes among children, and the following are his conclusions:

As a practical conclusion to be drawn from his observations, Schubert lays down the rule that all children should be taught a perpendicular handwriting. Even if the erect median position of copy book be not actually better than the oblique median, still the teacher cannot tell when inspecting writing done at home what absurd position may have been adopted in writing it, if the child is permitted to write anything but perpendicular letters. These latter can only be executed in the erect median position. It may be possible for adults to write more rapidly a slanting than a perpendicular hand, but children are not required to write rapidly, but in a manner that does not tend to deform their vertebral columns or their eyes. In many countries now-a-days, and in times past, perpendicular handwriting alone obtains, and Schubert appends a series of fac similes of German handwriting in every century from the 8th to the 18th inclusive. From this it is seen that slanting letters were not adopted to any extent until the 17th century.—*Ophthalmic Review*.

Condensed Pharmacy.

Some of the Paris pharmacists feel uneasy about the growing popularity of the medicinal alkaloids. They say that the time is not far distant when Sydenham's notion that the active usefulness of an entire drug store would sometime be carried around by doctors in the heads of their canes, is likely to be realized. The signs of the times certainly point to a future for medicine, in which composite drugs will be cleared of their useless components, and it does seem possible that the 8 ounce bottle prescription business may fall off a little. But as people become acquainted with the proper uses of the alkaloids they will certainly employ them much more frequently than they now use the massive mixtures of the older codices. A better instance of this than is shown in the growing popularity of citrate of caffeine, to which your correspondent has already referred, could hardly be cited. And then the pharmacist does a great deal of business with which the prescriptions of doctors have nothing to do. This kind of trade will increase with the exigencies of civilization. No living pharmacist will see the day when doctors will carry drug stores in their hats.—Paris correspondent of *Pharmaceutical Record*.

Terrible Mortality in New York City.

The deaths reported to the New York Health Board, on July 3d, numbered 256. This is the largest figure for one day since 1876.

Duties of the Druggist.

A correspondent of the *Western Druggist* in 1886 raised the question whether it was justifiable for a pharmacist to alter an excessive dose prescribed by a physician when uncertain whether such dose was prescribed, and unable to settle the matter by inquiry of the physician. As the following New York decision shows, this is not only justifiable, but it is the pharmacist's legal duty: A New York lady gave a pharmacist a prescription for a large quantity of laudanum, and at its foot was the following request by the physician: "Please give to bearer sixty drops in the store." The pharmacist declined to administer such a large quantity. He gave the lady ten drops because she was in pain; she begged him to give her such a dose as he would not be afraid to personally administer to her. Soon after these events the lady began a suit against the pharmacist in the Court of Common Pleas. She claimed \$10,000 damages, alleging that if he had given

her sixty drops of laudanum as requested she would have been saved from a miscarriage and its effects. The defence was that the ten drops of laudanum given by the druggist could not have affected her more than to temporarily lessen her pain, and that a pharmacist is not bound to personally administer dangerous drugs upon the order of a physician, his duty being simply to prepare medicines under the direction of physicians. Judge Beach sustained this view of the duty of a druggist, saying that a druggist would incur liability to indictment for manslaughter for having knowingly administered a drug or medicine which produced death.—*Western Druggist*.

Items.

—The *Lancet* computes that between five and six hundred individuals were treated for various casualties during the procession in London on Jubilee day.

—Some hilarious young men at Pittsburg dosed the drink of one of their companions so largely with croton oil "in fun" on the Fourth that he has since died.

—"Do you rectify mistakes here?" asked a gentleman, as he stepped into a drug store. "Yes, sir, we do, if the patient is still alive," replied the urbane clerk.

—"In the interest of the health of the community," a New Yorker informs the sanitary authorities of his city "that on Friday last a large snake came through the faucet."

—Bystander—Doctor, what do you think of this man's injuries?

Doctor—Humph! Two of them are undoubtedly fatal, but as for the rest of them time alone can tell.—*Texas Siftings*.

—Dr. W. Allan Jamison and M. Alexander Edington, of Edinburgh, announce in the *British Medical Journal*, of June 11th, that they have discovered a specific bacillus of scarlet fever which they claim is the specific cause of this disease.

—The chief of police of Chicago has issued orders giving the vehicles of physicians precedence at bridges, along with the mail and patrol wagons, ambulances and fire apparatus.

—To hear the doctors talk, one would suppose ice-cream to be a compound of deadly poisons, among which ptomaines, oxide of zinc, lead and various adulterants find prominent place. But it rather upsets one's faith again to see the same doctors quietly swallowing large quantities of the dangerous stuff.

—An instance of the late Senator Carpenter's wit, and at the same time a striking illustration of "the ruling passion strong in death," occurred when he lay on his death-bed. He inquired of his attending physician what was the matter with him, and when the doctor informed him that it was "a stoppage of the colon," the Senator remarked, that "I am glad it is not a full stop."

—Apoplexy, induced by excessive laughter, was given at the inquest as the cause of the death of a young woman, in Sheffield, England, lately. She had been highly amused at the predicament into which a neighbor got, and broke into a fit of laughter which continued until she fell to the floor unconscious, death following shortly afterwards.

—A NEW KIND OF INSOMNIA.—A professor in a certain college, who complained of insomnia, was advised to consult a celebrated physician. He did so, and the latter, after a thorough examination of all the vital organs, pronounced the professor absolutely sound. "I am at a loss," the doctor said, "to account for it. You seem perfectly well. Perhaps something is preying upon your mind?" "Oh, no," said the professor, "nothing at all." "Perhaps you have some business cares?" "No: nothing of that sort." "And yet you say that you get no sleep at night?" "Oh, no! I never said that. I'm all right at night; but it's insomnia in the daytime that bothers me!"

—Statements have been made at various times that the seeds found in ancient Egyptian tombs have germinated, but it is pointed out by Mr. George Murray in *Nature* that competent botanists have universally condemned as worthless the evidence given in support of the alleged germination of mummy seeds. For example, the mummy wheat of one well-known traveller grew up as oats (!) a plant which was unknown to the ancient Egyptian, but which is now cultivated in the country. The Arabs are understood to mislead travellers.

—The recent serious and nearly fatal illness of Prof. Billroth, from which he is now convalescent, consisted at first in a sharp attack of bronchitis which confined him to his bed. Then acute pneumonia supervened. These conditions, combined with fatty degeneration of the heart, brought about a state of alarming prostration. He appears to have derived most benefit from inhalations of pure oxygen, which were prepared for him every day.

—Lanolin was official in a Madrid Pharmacopœia in 1797.

OBITUARIES.

DR. HENRY CARPENTER.

Dr. Henry Carpenter, oldest practicing physician and head of his profession in Lancaster county, died on July 9, 1887, in the 68th year of his age, of paralysis. He was first stricken on April 13th, and received the third fatal stroke July 3d.

Dr. Carpenter was born on December 10, 1819, in Lancaster. He came from a race of physicians. The hanging lantern, dated 1698, now in his possession, was brought over here by his paternal ancestor, Dr. Henry Carpenter (Zimmermann), who came to Germantown from Switzerland in that year, and moved to West Earl, in 1717.

Dr. Carpenter graduated at the Pennsylvania Medical College in February, 1841, when he returned to Lancaster, and began practice in the office which he occupied during all of his practice, and which his father formerly occupied as conveyancer. He was one of the founders of the Lancaster County Medical Society in 1844, Secretary from its organization for many years, and its President in 1855. He was Secretary and Vice-President of the State Medical Society, and one of the Board of Censors for the Eastern District of Pennsylvania. After he was fully started in his profession he discovered that the obstetrical forceps then in use, those of Hayden, Smellie and Baudelocque, were not all that could be desired, and in 1843 he drew plans for forceps that were manufactured for him in Philadelphia by Mr. Gemrig, and which he used for forty-four years. His early training rather cultivated a taste for obstetrics, and, while he had no specialty, he nevertheless had a very large obstetrical experience; those in his own individual practice, together with consultation, amounting to nearly 5,500 cases. While Dr. Carpenter devoted much time to obstetrics and gynecology, he was a practical surgeon in the most general acceptance of the term, having operated extensively in almost every affection which calls for surgical interference. He was never connected with any of our public hospitals, and therefore his extensive experience in operating for strangulated hernia seems the more remarkable. Up to July 1, 1871, the ledger shows that he had 246 cases, and these embrace every variety of this affection. One of the most brilliant operations he ever

performed was the ligation of the gluteal artery, and so far as we have been able to discover there is no record of this having been done before in the State.

DR. LOUIS BOUDINOT HUNTER.

Louis Boudinot Hunter, Medical Director of the United States Navy, died recently in this city at the age of eighty-three. He was a native of New Jersey, and entered the Naval Academy in 1828, and in 1833 was attached to the frigate Hudson, of the Brazilian Squadron, as Assistant Surgeon. At the outbreak of the Rebellion he was Fleet Surgeon in the service off the coast of Brazil. After some service on the Retiring Board, he was rendezvoused at the Navy Yard in this city from 1863 to the fall of 1864, when he sailed as Fleet Surgeon of the North Atlantic Squadron. From 1866 to 1879 he was stationed at the Philadelphia Navy Yard, on the Board of Examination, and from 1872 to 1873 was attached to the Gray's Ferry Naval Asylum, being retired in the latter year with the rank of Medical Director, U. S. N.

DR. LEWIS B. HUNTER.

Dr. Lewis B. Hunter, medical director on the retired list of the U. S. Navy, died in Philadelphia on June 24th, at the age of 83 years. Dr. Hunter was a native of New Jersey, and was appointed an assistant surgeon in the Navy in January, 1828.

Changes in the Medical Corps of the Navy for the week ending July 9, 1887:

Medical Inspector, A. Hudson, detached from the "Trenton," and awaits orders.

Medical Inspector, W. K. Scofield, ordered to relieve Medical Inspector Hudson on the "Trenton."

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from July 3, 1887, to July 9, 1887:

Major Wm. S. Tremaine, Surgeon, ordered for examination by Army Retiring Board, at Governor's Island, N. Y. Harbor. S. O. 155, A. G. O., July 1, 1887.

Capt. J. O. Skinner, Assistant Surgeon, granted leave of absence for six months on surgeon's certificate of disability. S. O. 151, A. G. O., July 1, 1887.

1st Lieut., H. S. T. Harris, Assistant Surgeon, will be relieved from duty at Ft. Ringgold, Tex., upon the return of Assistant Surgeon W. F. Carter, and will then report to Commanding Officer at Fort McIntosh, Tex., for duty. S. O. 73, Dp. Texas, June 27, 1887.